2020

elderplan®

Caring every minute, every day.

Summary of Benefits

Elderplan Extra Help (HMO)

January 1, 2020 to December 31, 2020

H3347_EP16713_M

Summary of Benefits

for Elderplan Extra Help (HMO)

January 1, 2020 - December 31, 2020

Bronx, Kings, New York, Queens, and Westchester

H3347_EP16713_M

Proposed Effective Date_____/_____/ _____

Primary Care Provider

Name _____

Address _____

Phone Number ( ) _____

Name of Sales Representative _____

Important Numbers

Member Services: 1-800-353-3765, TTY 711, 8 am to 8 pm, 7 days a week

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Section I: Introduction To Summary Of Benefits

Elderplan is an HMO plan with Medicare and Medicaid contracts. Enrollment in Elderplan depends on contract renewal. Anyone entitled to Medicare Parts A and B may apply. Enrolled members must continue to pay their Medicare part B premium if not otherwise paid for under Medicaid.

This booklet gives you a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, see the 2020 Elderplan Extra Help (HMO) Evidence of Coverage. A copy of the Evidence of Coverage is located on our website at www.elderplan.org.

IN THIS BOOKLET WE DESCRIBE

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ELDERPLAN CONTACT INFORMATION

ELDERPLAN EXTRA HELP HOURS OF OPERATION

- From October 1 to March 31, you can call us 7 days a week from 8 am to 8 pm Eastern time.
- From April 1 to September 30, you can call us Monday through Friday from 8am to 8 pm Eastern time.

ELDERPLAN EXTRA HELP PHONE NUMBERS AND WEBSITE

- If you are a member of this plan, call toll-free 1-800-353-3765. (TTY users should call 711.) Hours are 8 am to 8 pm, 7 days a week.
- If you are not a member of this plan, call toll-free 1-866-695-8101. (TTY users should call 711.) Hours are 8 am to 8 pm, 7 days a week.
- Our website: www.elderplan.org

This document is available for free in Spanish. Please contact our Member Services number at 1-800-353-3765 for additional information. (TTY users should call 711.) Hours are 8 am to 8 pm, 7 days a week. This information is also available in different formats, including Braille or other alternate formats. Please call Member Services at the number listed above if you need plan information in another format or language.

WHO CAN JOIN?

To join Elderplan Extra Help (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in New York: Bronx, Kings, New York, Queens, and Westchester.

USEFUL INFORMATION

You have choices about how to get your Medicare Benefits

- One choice is to get your Medicare benefits through Original Medicare (fee- for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Elderplan Extra Help (HMO).

Tips for comparing your Medicare Choices

This Summary of Benefits booklet gives you a summary of what Elderplan Extra Help (HMO) covers and what you pay.

- You can compare Elderplan Extra Help and Original Medicare using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers. Our members receive all of the benefits that Original Medicare offers. The covered benefits may change from year to year.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.

INFORMATION ABOUT ELDERPLAN EXTRA HELP

Eligibility requirements for our plan

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B;
- -- *and* -- You live in our geographic service area: Bronx, Kings, New York, Queens, and Westchester;
- -- *and* -- You are a United States citizen or are lawfully present in the United States;
- -- *and* -- You do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

Which Doctors, Hospitals, Pharmacies can I use?

Elderplan Extra Help (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, we may not pay for these services except in emergency situations. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's Provider and Pharmacy Directory at our website www.elderplan.org or, call us and we will send you a copy of the Provider and Pharmacy Directory.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers and more.

- Members get all of the benefits covered by Original Medicare.
- Members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.
- We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.elderplan.org or call us and we will send you a copy of the formulary.

How will I determine my drug costs?

The amount you pay for drugs depends on the drug you are taking, what "drug payment stage" you have reached, and the plan cost-sharing tiers.

Later in this document we discuss the drug payment stages and the plan cost-sharing tiers. The drug payment stages are the Deductible Stage, Initial Coverage Stage, Coverage Gap, and Catastrophic Coverage Stage. Every drug on the plan's Drug List is in one of five cost-sharing tiers:

- Tier 1: Preferred Generic Drugs (lowest cost-sharing tier)
- Tier 2: Generic Drugs
- Tier 3: Preferred Brand Drugs
- Tier 4: Non-preferred Brand Drugs
- Tier 5: Specialty Tier Drugs (highest cost-sharing tier)

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see the Evidence of Coverage (*Chapter 2, Section 7)*.

Section II: Summary of Benefits

The following are the health care costs for Elderplan Extra Help.

Elderplan Extra Help (HMO)	
Monthly Plan Premium	$23.80 per month for the Part D premium. In addition, you must keep paying your Medicare Part B premium.
Deductible	$0 This plan has no Part B Deductible. However, the plan has a deductible for certain types of medical services and Part D prescription drugs.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$6,700 Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the maximum out-of-pocket costs, we will pay the full cost of your covered hospital and medical services for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Elderplan Extra Help (HMO)	
Inpatient Hospital Coverage	A per admission deductible is applied once during the defined benefit period. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. In 2020 the amounts for each benefit period are: $1,408 deductible. Days 1-60: $0 copayment per day. Days 61-90: $352 copayment per day. Days 91 and beyond: $704 copayment per lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime).

Elderplan Extra Help (HMO)	
Inpatient Hospital Coverage (continued)	Beyond lifetime reserve days: you pay all costs. Authorization is required. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital
Outpatient Hospital Coverage	There is no coinsurance or copayment for Lab Services. 20% coinsurance for each of the following Medicare-covered services: • Outpatient Hospital Services. • Partial Hospitalization Services. Authorization is required. • Outpatient Diagnostic Procedures/Tests. • X-Ray Services. • Diagnostic Radiological services. Authorization is required ONLY for Positron Emission Tomography (PET), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), and CAT Scan (CT).

Elderplan Extra Help (HMO)	
Outpatient Hospital Coverage (continued)	• Therapeutic Radiological Services. • Prosthetic Devices or Medical Supplies. Authorization is required. • Medicare Part B prescription drugs. Authorization is required for certain items.
Doctor Visits (Primary Care Providers and Specialists)	$0 copayment for Primary Care Physician visits. $40 copayment for Specialist visits. 20% coinsurance for Other Health Care Professional (such as Physician Assistants, Nurse Practitioners, Social Workers, Physical Therapists, and Psychologist) Services. Authorization is only required for in-home visits billed by a Nurse Practitioner or Physician's Assistant directly.
Preventive Care	$0 cost-sharing for the following preventive services: • Annual "Wellness" visit • Abdominal aortic aneurysm screening • Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing

Elderplan Extra Help (HMO)	
Preventive Care (continued)	• Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes Self-Management training • HIV screening • Immunizations including: Flu shots, Hepatitis B shots, Pneumococcal shots • Medical nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to prevent alcohol misuse • Screening for Lung Cancer with low dose computed tomography (LDCT) • Sexually transmitted infection (STI) screening and counseling to prevent STIs • Smoking and Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • "Welcome to Medicare" Preventive Visit (one-time) • Other preventive services may be covered if approved by Medicare.

Elderplan Extra Help (HMO)	
Emergency Care	$90 copayment for each visit. If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay this copayment.
Urgently Needed Services	$35 copayment for each visit. If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay this copayment.
Diagnostic Services/Labs/Imaging	$0 copayment for each of the following services: • Outpatient Blood Services. • Lab Services. 20% coinsurance for each of the following Medicare-covered services: • Outpatient Diagnostic Procedures/Tests. • X-Ray Services. • Diagnostic Radiological services. Authorization is required ONLY for Positron Emission Tomography (PET), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), and CAT Scan (CT).

Elderplan Extra Help (HMO)	
Diagnostic Services/Labs/Imaging (continued)	• Occupational, Physical, and/or Speech/Language Therapy service. • Authorization is required. • Therapeutic Radiological Services. • Prosthetic Devices or Medical Supplies. Authorization is required.
Hearing Services	20% coinsurance for Medicare-covered diagnostic hearing exams. $0 copayment for the following (once every 3 years): • Non-Medicare covered Routine Hearing Exam. • Fitting/Evaluation for Hearing Aid. • Hearing Aids (all types) up to $500 total for one single ear. One single hearing aid every 3 years. Authorization is required by a Physician or Specialist.

Elderplan Extra Help (HMO)

Dental Services – <u>Preventative Dental Services</u>:

Benefit frequency may be limited per American Dental Association guidelines.

There is no coinsurance or copayment for the following preventative dental services:

DIAGNOSTIC & PREVENTIVE SERVICES			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Periodic Oral Exam	D0120	No charge	Once every 6 months
Limited Oral Exam	D0140	No charge	Once every 6 months
Comprehensive Oral Exam	D0150	No charge	Once every 6 months
Problem Focused Oral Exam	D0160	No charge	Once every 6 months
Follow up Exam	D0170	No charge	Once every 6 months
Comprehensive Periodontal Exam	D0180	No charge	Once every 6 months
Complete Series X-rays	D0210	No charge	Once every 36 months
Periapical X-ray	D0220	No charge	Once every 12 months
Periapical X-ray, each additional film	D0230	No charge	Once every 12 months
Occlusal X-ray	D0240	No charge	Once every 12 months
2-D Projection X-ray	D0250	No charge	Once every 12 months
Bitewing X-ray – single image	D0270	No charge	Once every 12 months
Bitewing X-ray – two images	D0272	No charge	Once every 12 months
Bitewing X-ray – three images	D0273	No charge	Once every 12 months
Bitewing X-ray – four images	D0274	No charge	Once every 12 months
Vertical Bitewing X-rays – seven to eight images	D0277	No charge	Once every 12 months
Panoramic X-ray	D0330	No charge	Once every 12 months
Cephalometric X-ray	D0340	No charge	Once every 12 months
2-D Photographic Images	D0350	No charge	Once every 12 months
Prophylaxis (Cleaning) – Adult	D1110	No charge	Once every 6 months
Prophylaxis (Cleaning) – Child	D1120	No charge	Once every 6 months

Elderplan Extra Help (HMO)

Dental Services – <u>Comprehensive Dental Services</u>:

20% coinsurance for Medicare-covered services.

Medicare will only pay for certain Dental Services that you get when you're in a hospital. Medicare can pay for inpatient hospital care if you need to have an emergency or complicated dental procedure.

Benefit frequency may be limited per American Dental Association guidelines.

†A referral is required for Comprehensive Dental Services. For more information about exclusions and limitations please see your Dental Handbook.

Coverage of Supplemental Comprehensive Dental Services is limited to select service codes from the categories below:

COMPREHENSIVE SERVICES			
Restorative Services †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Silver Filling – Once Surface	D2140	No charge	Once every 24 months, per tooth
Silver Filling – Two Surfaces	D2150	No charge	Once every 24 months, per tooth
Silver Filling – Three Surfaces	D2160	No charge	Once every 24 months, per tooth
Silver Filling – Four or More Surfaces	D2161	No charge	Once every 24 months, per tooth
Tooth-colored Filling – One Surface, Front	D2330	No charge	Once every 24 months, per tooth
Tooth-colored Filling – Two Surfaces, Front	D2331	No charge	Once every 24 months, per tooth
Tooth-colored Filling – Three Surfaces, Front	D2332	No charge	Once every 24 months, per tooth

Elderplan Extra Help (HMO)			
COMPREHENSIVE SERVICES (continued)			
Restorative Services (continued) †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Tooth-colored Filling – Four or More Surfaces, Front	D2335	No charge	Once every 24 months, per tooth
Tooth-colored Crown – Front	D2390	No charge	Once every 24 months, per tooth
Tooth-colored Filling – One Surface, Back	D2391	No charge	Once every 24 months, per tooth
Tooth-colored Filling – Two Surfaces, Back	D2392	No charge	Once every 24 months, per tooth
Tooth-colored Filling – Three Surfaces, Back	D2393	No charge	Once every 24 months, per tooth
Tooth-colored Filling – Four or More Surfaces, Back	D2394	No charge	Once every 24 months, per tooth
Inlay – Metallic, One Surface	D2510	$250	Once every 60 months, per tooth
Inlay – Metallic, Two Surfaces	D2520	$250	Once every 60 months, per tooth
Inlay – Metallic, Three or MoreSurfaces	D2530	$250	Once every 60 months, per tooth
Onlay – Metallic, Two Surfaces	D2542	$250	Once every 60 months, per tooth
Inlay – Porcelain/Ceramic, TwoSurfaces	D2620	$250	Once every 60 months, per tooth
Inlay – Porcelain/Ceramic, Three or More Surfaces	D2630	$250	Once every 60 months, per tooth
Crown – Tooth Colored	D2710	$250	Once every 60 months, per tooth
Crown – 3/4 Tooth Colored	D2712	$250	Once every 60 months, per tooth
Crown – Tooth Colored with High Noble Metal	D2720	$250	Once every 60 months, per tooth
Crown – Tooth Colored with Predominantly Base Metal	D2721	$250	Once every 60 months, per tooth
Crown – Tooth Colored with Noble Metal	D2722	$250	Once every 60 months, per tooth
Crown – Porcelain/ Ceramic Substrate	D2740	$250	Once every 60 months, per tooth

Elderplan Extra Help (HMO)			
COMPREHENSIVE SERVICES (continued)			
Restorative Services (continued) †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Crown – Porcelain Fused to High Noble Metal	D2750	$250	Once every 60 months, per tooth
Crown – Porcelain Fused to Predominantly Base Metal	D2751	$250	Once every 60 months, per tooth
Crown – Porcelain Fused to NobleMetal	D2752	$250	Once every 60 months, per tooth
Crown – Full Cast High Noble Metal	D2790	$250	Once every 60 months, per tooth
Crown – Full Cast Predominantly Base Metal	D2791	$250	Once every 60 months, per tooth
Crown – Full Cast Noble Metal	D2792	$250	Once every 60 months, per tooth
Re-cement or Re-bond Inlay, Onlay or Veneer	D2910	No charge	Once every 6 months, per tooth
Re-cement or Re-bond Crown	D2920	No charge	Once every 6 months, per tooth
Reattachment of Tooth Fragment	D2921	No charge	Once every 6 months, per tooth
Stainless Steel Crown, Baby Tooth	D2930	No charge	Once every 60 months, per tooth
Stainless Steel Crown, Adult Tooth	D2931	No charge	Once every 60 months, per tooth
Pin Retention	D2951	No charge	Once every 60 months, per tooth
Post and Core in Addition to Crown	D2952	$50	Once every 60 months, per tooth
Each Additional Indirectly Fabricated Post – Same Tooth	D2953	$50	Once every 60 months, per tooth
Prefabricated Post and Core in Addition to Crown	D2954	$50	Once every 60 months, per tooth
Endodontic Services †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Therapeutic Pulpotomy	D3220	No charge	Once per lifetime, per tooth
Pulpal Therapy, Front Tooth	D3230	No charge	Once per lifetime, per tooth
Pulpal Therapy, Back Tooth	D3240	No charge	Once per lifetime, per tooth
Root Canal Therapy, Front Tooth	D3310	No charge	Once per lifetime, per tooth
Root Canal Therapy, Bicuspid Tooth	D3320	No charge	Once per lifetime, per tooth

Elderplan Extra Help (HMO)			
COMPREHENSIVE SERVICES (continued)			
Endodontic Services † (continued)			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Root Canal Therapy, Back Tooth	D3330	$40	Once per lifetime, per tooth
Retreatment of Root Canal Therapy, Front Tooth	D3346	No charge	Once per lifetime, per tooth
Retreatment of Root Canal Therapy, Bicuspid Tooth	D3347	No charge	Once per lifetime, per tooth
Retreatment of Root Canal Therapy, Back Tooth	D3348	$40	Once per lifetime, per tooth
Apicoectomy, Front Tooth	D3410	$40	Once per lifetime, per tooth
Apicoectomy, Bicuspid Tooth – First Root	D3421	$40	Once per lifetime, per tooth
Apicoectomy, Back Tooth – First Root	D3425	$40	Once per lifetime, per tooth
Apicoectomy, Each Additional Root	D3426	$40	Once per lifetime, per tooth
Periradicular Surgery without Apicoectomy	D3427	$40	Once per lifetime, per tooth
Retrograde Filling – Per Root	D3430	$40	Once per lifetime, per tooth
Periodontic Services †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Gingivectomy – Four or More Teeth	D4210	$40	Once per 36 months, per quadrant
Osseous Surgery – Four or More Teeth	D4260	$300	Once per 60 months, per quadrant
Osseous Surgery – One to Three Teeth	D4261	$150	Once per 60 months, per quadrant
Periodontal Scaling and Root Planing, Four or More Teeth	D4341	No charge	Once per 36 months, per quadrant
Periodontal Scaling and Root Planing, One to Three Teeth	D4342	No charge	Once per 36 months, per quadrant
Full Mouth Debridement	D4355	No charge	Once per 36 months
Periodontal Maintenance	D4910	No charge	Once per 36 months

Elderplan Extra Help (HMO)			
COMPREHENSIVE SERVICES (continued)			
Maxillofacial Services – Removable †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Full Upper Denture	D5110	$300	Once per 60 months
Full Lower Denture	D5120	$300	Once per 60 months
Full Upper Immediate Denture	D5130	$300	Once per 60 months
Full Lower Immediate Denture	D5140	$300	Once per 60 months
Partial Upper Denture – Resin Based	D5211	$300	Once per 60 months
Partial Lower Denture – Resin Based	D5212	$300	Once per 60 months
Partial Upper Denture – Cast Metal	D5213	$300	Once per 60 months
Partial Lower Denture – Cast Metal	D5214	$300	Once per 60 months
One-Sided Partial Denture – Cast Metal, Upper	D5282	$300	Once per 60 months
One-Sided Partial Denture – Cast Metal, Lower	D5283	$300	Once per 60 months
Full Upper Denture Adjustment	D5410	No charge	
Full Lower Denture Adjustment	D5411	No charge	
Partial Upper Denture Adjustment	D5421	No charge	
Partial Lower Denture Adjustment	D5422	No charge	
Repair Broken Denture, Full Denture	D5510	No charge	Once per 12 months
Replace Missing or Broken Tooth, Full Denture	D5520	No charge	Once per 12 months
Repair Denture Base, Partial Denture	D5610	No charge	Once per 12 months
Repair Cast Frame, Partial Denture	D5620	No charge	Once per 12 months
Repair/Replace Broken Clasp, per Tooth – Partial Denture	D5630	No charge	Once per 12 months
Replace Broken Tooth – Partial Denture	D5640	No charge	Once per 12 months

Elderplan Extra Help (HMO)			
COMPREHENSIVE SERVICES (continued)			
Maxillofacial Services – Removable (continued) †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Add Tooth to Existing Partial Denture	D5650	No charge	Once per 12 months
Add Clasp to Existing Partial Denture	D5660	No charge	Once per 12 months
Rebase Full Upper Denture	D5710	No charge	Once per 12 months
Rebase Full Lower Denture	D5711	No charge	Once per 12 months
Rebase Partial Upper Denture	D5720	No charge	Once per 12 months
Rebase Partial Lower Denture	D5721	No charge	Once per 12 months
Reline Full Upper Denture, in Office	D5730	No charge	Once per 12 months
Reline Full Lower Denture, in Office	D5731	No charge	Once per 12 months
Reline Partial Upper Denture, in Office	D5740	No charge	Once per 12 months
Reline Partial Lower Denture, in Office	D5741	No charge	Once per 12 months
Reline Full Upper Denture, in Lab	D5750	No charge	Once per 12 months
Reline Full Lower Denture, in Lab	D5751	No charge	Once per 12 months
Reline Partial Upper Denture, in Lab	D5760	No charge	Once per 12 months
Reline Partial Lower Denture, in Lab	D5761	No charge	Once per 12 months
Overdenture, Complete	Obsolete Code D5860	Please see new codes listed below for Overdenture services.	
Overdenture, Partial	Obsolete Code D5861		

Elderplan Extra Help (HMO)			
COMPREHENSIVE SERVICES (continued)			
Maxillofacial Services – Removable (continued) †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Overdenture, Full Upper	New Code D5863	$300	Once per 60 months
Overdenture, Partial Upper	New Code D5864	$300	Once per 60 months
Overdenture, Full Lower	New Code D5865	$300	Once per 60 months
Overdenture, Partial Lower	New Code D5866	$300	Once per 60 months
Prosthodontic Services – Fixed †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Pontic – Indirect Resin Based Composite	D6210	$300	Once per 60 months, per tooth
Pontic – Cast Predominantly Base Metal	D6211	$300	Once per 60 months, per tooth
Pontic – Cast Noble Metal	D6212	$300	Once per 60 months, per tooth
Pontic – Porcelain Fused to High Noble Metal	D6240	$300	Once per 60 months, per tooth
Pontic – Porcelain Fused to Predominantly Base Metal	D6241	$300	Once per 60 months, per tooth
Pontic – Porcelain Fused to Noble Metal	D6242	$300	Once per 60 months, per tooth
Pontic – Resin with High Noble Metal	D6250	$300	Once per 60 months, per tooth
Pontic – Resin with Predominantly Base Metal	D6251	$300	Once per 60 months, per tooth
Pontic – Resin with Noble Metal	D6252	$300	Once per 60 months, per tooth
Retainer – Cast Metal for Resin Bonded	D6545	$300	Once per 60 months, per tooth

Elderplan Extra Help (HMO)			
COMPREHENSIVE SERVICES (continued)			
Prosthodontic Services – Fixed (continued) †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Retainer Onlay – Cast High Nobel Metal, Two Surface	D6610	$300	Once per 60 months, per tooth
Retainer Crown – Indirect Resin Based Composite	D6710	$300	Once per 60 months, per tooth
Retainer Crown – Resin with High Noble Metal	D6720	$300	Once per 60 months, per tooth
Retainer Crown – Resin with Predominantly Base Metal	D6721	$300	Once per 60 months, per tooth
Retainer Crown – Resin with Noble Metal	D6722	$300	Once per 60 months, per tooth
Retainer Crown – Porcelain/Ceramic	D6740	$300	Once per 60 months, per tooth
Retainer Crown – Porcelain Fused to High Noble Metal	D6750	$300	Once per 60 months, per tooth
Retainer Crown – Porcelain Fused to Predominantly Base Metal	D6751	$300	Once per 60 months, per tooth
Retainer Crown – Porcelain Fused to Noble Metal	D6752	$300	Once per 60 months, per tooth
Retainer Crown – Full Cast High Noble Metal	D6790	$300	Once per 60 months, per tooth
Retainer Crown – Full Cast Predominantly Base Metal	D6791	$300	Once per 60 months, per tooth
Retainer Crown – Full Cast Noble Metal	D6792	$300	Once per 60 months, per tooth
Re-cement or Re-bond, per Unit	D6930	No charge	
Oral Surgery & Maxillofacial Services †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Routine Extraction	D7140	No charge	Once per lifetime, per tooth
Surgical Extraction	D7210	No charge	Once per lifetime, per tooth
Extraction – Soft Tissue Impaction	D7220	No charge	Once per lifetime, per tooth
Extraction – Partial Bony Impaction	D7230	$100	Once per lifetime, per tooth
Extraction – Full Bony Impaction	D7240	$100	Once per lifetime, per tooth
Extraction – Full Bony with Complications	D7241	$100	Once per lifetime, per tooth
Removal of Roots	D7250	$100	Once per lifetime, per tooth
Oroantral Fistula Closure	D7260	$100	Once per lifetime, per tooth

Elderplan Extra Help (HMO)			
COMPREHENSIVE SERVICES (continued)			
Oral Surgery & Maxillofacial Services (continued) †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Exposure of Unerupted Tooth	D7280	$100	Once per lifetime, per tooth
Mobilization of Erupted or Malpositioned Tooth to Help Eruption	D7282	$100	Once per lifetime, per tooth
Alveoloplasty, with Extraction	D7310	No charge	Once per lifetime, per quadrant
Alveoloplasty, without Extraction	D7320	No charge	Once per 12 months, per quadrant
Vestibuloplasty	D7340	$100	
Removal of Benign Lesion <1.25 cm	D7410 **Medical Codes:** 40810, 40812, 40814	$100	
Removal of Benign Lesion >1.25 cm	D7411 **Medical Codes:** 21034, 21044	$100	
Removal of Malignant Lesion <1.25 cm	D7440 **Medical Codes:** 21034, 21044	$100	
Removal of Malignant Lesion >1.25 cm	D7441 **Medical Codes:** 21034, 21044	$100	
Removal of Benign Cyst <1.25 cm	D7450 **Medical Codes:** 41825, 41826, 41827	$100	
Removal of Benign Cyst >1.25 cm	D7451 **Medical Codes:** 41825, 41826, 41827	$100	
Removal of Benign Non Tooth Structured Cyst <1.25 cm	D7460 **Medical Codes:** 41825, 41826, 41827	$100	
Removal of Benign Non Tooth Structured Cyst >1.25 cm	D7461 **Medical Codes:** 41825, 41826, 41827	$100	

Elderplan Extra Help (HMO)			
COMPREHENSIVE SERVICES (continued)			
Oral Surgery & Maxillofacial Services (continued) †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Removal of Lateral Exostosis (Upper or Lower)	D7471 **Medical Codes:** 21031, 21032	$100	
Removal of Tori on Lower Jaw	D7473	$100	
Incision and Drainage, Intraoral	D7510	$100	
Incision and Drainage, Extraoral	D7520 **Medical Codes:** 40801, 41800	$100	
Frenectomy	D7960	$100	
Removal of Hyperplastic Tissue	D7970	$100	
Removal of Pericoronal Gingiva	D7971	$100	
Adjunctive General Services †			
COVERED SERVICES	**CODES**	**COPAYMENT**	**FREQUENCY**
Emergency Treatment	D9110	No charge	
Local Anesthesia, not in Conjunction with Surgical or Operative Procedure	D9210	No charge	
Regional Block – Local Anesthesia	D9211	No charge	
Trigeminal Division Block Anesthesia	D9212	No charge	
Local Anesthesia, in Conjunction with Surgical or Operative Procedure	D9215	No charge	
Specialist Consultation	D9310	No charge	
Office Visit for Observation During Regular Office Hours	D9430	No charge	
Occlusal Adjustment – Limited	D9951	No charge	
Occlusal Adjustment – Complete	D9952	No charge	

Elderplan Extra Help (HMO)	
Vision Services	$25 copayment for Medicare-covered preventative and diagnostic eye exams (including eye exams if you have diabetes, and macular degeneration tests and treatment). $0 Copayment for Medicare-covered glaucoma screening. $0 Copayment for one routine **eye exam** for eyewear every year. $0 Copayment for **eyewear** ($100 annual maximum per calendar year) including contact lenses or eyeglasses (lenses and frames). $0 Copayment for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. Eyewear provided after cataract surgery are not subject to the annual maximum amount ($100).

Elderplan Extra Help (HMO)	
Mental Health Services	<u>Outpatient</u> **Mental Health Specialty:** • $20 copayment for each Outpatient Mental Health Specialty Individual Session. • $5 copayment for each Outpatient Mental Health Specialty Group Session. **Psychiatric Services:** • $25 copayment for each Psychiatric Service Individual Session. • $5 copayment for each Psychiatric Service Group Session. For Outpatient Mental Health Services, if your provider offers telehealth, you pay $10 copayment for each telehealth service. <u>Inpatient</u> A per admission deductible is applied once during the defined benefit period. Our plan covers up to 90 days of medically necessary hospitalization for each benefit period.

Elderplan Extra Help (HMO)	
Mental Health Services (continued)	Our plan also covers up to 60 additional lifetime reserve days. 90 Days are given for each benefit period, but the 60 lifetime reserve days can be used only once during the beneficiary's lifetime for care provided in either an acute care hospital or a psychiatric hospital. Our plan covers up to 40 additional days in a Psychiatric hospital. The 40 additional Psychiatric days are offered once during the beneficiary lifetime. Payment may not be made for more than a total of 190 days of inpatient psychiatric care in a freestanding psychiatric hospital during the patient's lifetime. In 2020 the amounts for each benefit period are: $1,408 deductible. Days 1-60: $0 copayment per day. Days 61-90: $352 copayment per day.

Elderplan Extra Help (HMO)	
Mental Health Services (continued)	Days 91 and beyond: $704 copayment per lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: you pay all costs. You pay 20% of the Medicare-approved amount for mental health services you get from doctors and other providers while you're a hospital inpatient. Authorization is required.
Skilled Nursing Facility	The plan covers up to 100 days each benefit period (a 3-day minimum prior hospital stay for a related illness or injury is required). In 2020 the amounts for each benefit period after at least a 3-day Medicare covered hospital stay are: Days 1 - 20: $0 per day Days 21 - 100: $176 copayment per day Days 101 and beyond: you pay all costs. Authorization is required.

Elderplan Extra Help (HMO)	
Physical Therapy	20% coinsurance for each service. Authorization is required.
Ambulance	20% coinsurance for each one-way trip. Authorization is required for non-emergency services.
Transportation	Not covered
Medicare Part B Drugs	20% coinsurance for each Medicare Part B prescription drugs. Authorization is required for certain items.
Ambulatory Surgical Center	20% coinsurance for Outpatient Surgery at an Outpatient Hospital or Ambulatory Surgical Center. There is no coinsurance or copayment for a Diagnostic Colonoscopy in an Ambulatory Surgical Center.

Outpatient Prescription Drugs	
Part D Premium	$23.80 per month
Part D Deductible Stage	Tier 1, 2 and 3 Drugs: $0 Deductible Tier 4 and 5 Drugs: $435 Deductible During this stage you pay the full cost of your Tier 4 and 5 drugs.
Initial Coverage Stage	After you pay your yearly deductible, you stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $4,020. Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).

Outpatient Prescription Drugs				
Tiers: Tier Name	**Deductible**	**Initial Coverage Stage**		
		Retail Pharmacy Cost (30-Day Supply)*	Retail Pharmacy Cost (90-Day Supply)^	MAIL Order Pharmacy Cost (90-Day Supply)
Tier 1: Preferred Generic Drugs	$0	$4 copayment	$12 copayment	$8 copayment
Tier 2: Generic Drugs		$20 copayment	$60 copayment	$40 copayment
Tier 3: Preferred Brand Drugs		$47 copayment	$141 copayment	$94 copayment
Tier 4: Non-Preferred Drugs	$435	$100 copayment	$300 copayment	$200 copayment
Tier 5: Specialty Tier Drugs		25% coinsurance	25% coinsurance	25% coinsurance

* One-month supply for Standard retail (in-network), Long-term care, and Out-of-network cost-sharing.

^ 60-Day supply is also available for Standard retail (in-network).

Outpatient Prescription Drugs	
Coverage Gap Stage	In the Coverage Gap Stage (also called the "donut hole") there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. During this stage, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage Stage	Once your out-of-pocket costs have reached $6,350, you enter the Catastrophic Coverage Stage. During this stage, you pay either a coinsurance or copayment, whichever is the larger amount: 5% coinsurance – or – For generic: $3.60 copayment For all other drugs: $8.95 copayment Our plan pays the rest of the cost.

Additional benefits covered by Elderplan Extra Help (HMO)

Elderplan Extra Help (HMO)	
Annual Physical Exam	$0 copayment for an annual Physical exam.
Diabetic Supplies and Services	There is no coinsurance or copayment for Medicare-covered Diabetes Supplies, Diabetes Self-Management Training, or Glaucoma Screenings. 20% coinsurance for Medicare-covered Diabetic Therapeutic Shoes or Inserts. Diabetic supplies are limited to specified manufacturers: Abbott Diabetes Care and Ascensia Diabetes Care.
OTC Items	You may purchase up to $55 every quarter (3 months) of eligible OTC items on an OTC card provided by Elderplan. The OTC card balance cannot be carried over to the next quarter.

Elderplan Extra Help (HMO)	
Health and Wellness Education Programs: Fitness Benefit (Gym)	$0 copayment for the Fitness Benefit. The Silver & Fit® Exercise and Healthy Aging program provides Elderplan members access to participating fitness centers and YMCAs. The fitness center membership includes standard center services such as access to cardiovascular equipment; free weights; resistance training equipment; and group exercise classes.
Opioid Treatment Services	$20 copayment for each service.
Worldwide Emergency/ Urgent Coverage	$65 copayment for each visit (if admitted to the hospital, there is no copayment). The maximum benefit coverage amount is $50,000.

Elderplan, Inc.
Notice of Nondiscrimination –
Discrimination is Against the Law

Elderplan/HomeFirst complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Elderplan, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Elderplan/HomeFirst:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Civil Rights Coordinator. If you believe that Elderplan/HomeFirst has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a grievance with:

Civil Rights Coordinator
6323 7th Ave
Brooklyn, NY, 11220
Phone: 1-877-326-9978, TTY 711
Fax: 1-718-759-3643

You may file a grievance in person or by mail, phone, or fax. If you need help filing a grievance, Civil Rights Coordinator, is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Multi-language Interpreter Services

ATTENTION: If you speak a non-English language or require assistance in ASL, language assistance services, free of charge, are available to you. Call 1-800-353-3765 (TTY: 711).

(Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-353-3765 (TTY: 711).

(Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-353-3765 (TTY: 711).

(Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-353-3765 (телетайп: 711).

(French Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-353-3765 (TTY: 711).

(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-353-3765 (TTY: 711)번으로 전화해 주십시오.

(Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-353-3765 (TTY: 711).

(Yiddish) אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט
1-800-353-3765 (TTY: 711).

(Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে৷ ফোন করুন 1-800-353-3765 (TTY: 711)৷

(Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-353-3765 (TTY: 711).

(Arabic)ملحوظة: إذا كنت تتحدث لغة غير الإنجليزية أو تحتاج إلى مساعدة في ASL، فإن خدمات المساعدة اللغوية تتوافر لك مجانا. اتصل برقم 1-800-353-3765 (TTY: 711).

(French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-353-3765 (ATS: 711).

(Urdu)خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
1-800-353-3765 (TTY: 711).

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-353-3765 (TTY: 711).

(Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-353-3765 (TTY: 711).

(Albanian) KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-353-3765 (TTY: 711).

elderplan homefirst®
a member of MJHS Health System

For more information, call us toll-free

1-800-353-3765

8 a.m. – 8 p.m., 7 days a week.

TTY/TDD users should call

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Visit our website

Elderplan.org

Elderplan is an HMO plan with Medicare and Medicaid contracts. Enrollment in Elderplan depends on contract renewal. Anyone entitled to Medicare Parts A and B may apply. Enrolled members must continue to pay their Medicare part B premium if not otherwise paid for under Medicaid.