2024

elderplan®

Leading the way to great care.℠

Summary of Benefits

Elderplan Extra Help (HMO-POS)

January 1, 2024 to December 31, 2024

H3347_EP17465_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 a.m. to 8 p.m., 7 days a week

elderplan®

Summary of Benefits

for **Elderplan Extra Help (HMO-POS)**

January 1, 2024 – December 31, 2024

Bronx, Kings, New York, Queens, and Westchester

About Elderplan

Elderplan is a member of MJHS Health System, a not-for-profit health care organization that was founded in 1907 by the Four Brooklyn Ladies based on the core values of compassion, dignity and respect. MJHS has a rich history of caring for at-risk New Yorkers of every race, ethnicity, faith, national origin, gender identity or expression, sexual orientation, and military status.

One of the many advantages of being an Elderplan/HomeFirst member is that we are part of the MJHS Health System family, which includes: MJHS Home Care, MJHS Hospice and Palliative Care, as well as MJHS Isabella and MJHS Menorah Centers for Rehabilitation and Nursing Care. So, should you require access to additional support over time, and choose to receive services from MJHS, the Elderplan team can work together with their colleagues from across the system to better coordinate your care.

Elderplan realizes that staying healthy is not always as easy as seeing the doctor or taking medications as prescribed. Unfortunately, gaps in access to quality health care based on race, ethnicity, gender, and financial stability are still all too often a factor. Consistent with our values, Elderplan is leading the way to great care by being committed to health equity, to closing these gaps in care, and ensuring that all our members have access to high-quality programs and services.

Elderplan Extra Help (HMO-POS)

Plan Overview

A health plan designed specifically for Medicare beneficiaries who are eligible for Extra Help. This plan offers medical, hospital and prescription drug coverage at little-or-no premium and low copays. Plus, extra benefits like the ability to see any dentist or specialist at no extra cost, a new expanded over-the-counter (OTC)* and Flex spending card, and a dedicated care management team that will be there to support and guide you, by helping to coordinate your benefits, answer your questions and more.

Members of this plan will also be able to participate in our Wellness Incentive Program (that rewards you for receiving eligible screenings and vaccinations), receive a gym membership to help you stay healthy, and have access to our award-wining Member-to-Member program.

Elderplan. Leading the way to great care.

Contents

Benefits at a Glance

NEW! Freedom to choose any specialist or dentist at no additional cost	**$0**
Doctor Visits (Primary Care)	
Part B Deductible	
Expanded Acupuncture	
Brain Games with BrainHQ®	
Supplemental Preventive and Comprehensive Dental	
Routine Hearing	
Routine Vision	
Silver&Fit® Fitness Program	
Transportation	
24/7 Access to Care with Teladoc®	
Specialist Care	**$25**
Routine Podiatry	
Flex Card‡	**$500** every year
Over-the-Counter (OTC) Benefits	**$140** every quarter
NEW! Use your OTC benefit to purchase health related items, groceries, and meals too!*	

*For eligible members (with certain chronic conditions) the Special Supplemental Benefits for the Chronically Ill combines with the OTC benefit to cover certain grocery items and meals as part of the OTC allowance. Eligible members will be notified and provided instructions on how to access the benefit.

‡Flex Card benefit offers $500 allowance Card to use in 2024 on out-of-pocket costs for dental, vision, hearing, and/or fitness services.

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 or a third party.

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 2024 Elderplan Extra Help (HMO-POS) Evidence of Coverage. A copy of the Evidence of Coverage is located on our website at **www.elderplan.org**.

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 a.m. to 8 p.m. Eastern Time.
- From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. 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 a.m. to 8 p.m., 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 a.m. to 8 p.m., 7 days a week.
- Our website: **www.elderplan.org**.

This document is available for free in Spanish and Chinese. Please contact our Member Services number at **1-800-353-3765** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., 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-POS), 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 counties.

Useful Information About Medicare

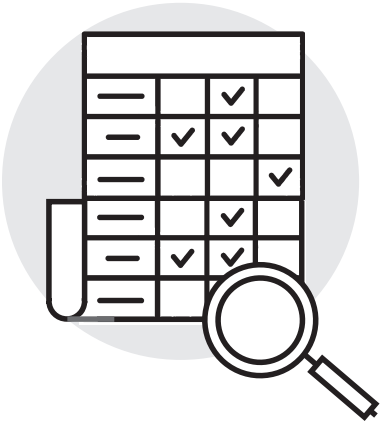
You have choices about how to get your Medicare Benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the federal government. Visit the Medicare website (**www.medicare.gov**).
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Elderplan Extra Help (HMO-POS)).

Tips for Comparing your Medicare Choices

This Summary of Benefits booklet gives you a summary of what Elderplan Extra Help (HMO-POS) 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 **https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf** 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 **www.medicare.gov/plan-compare**.

Information About Elderplan Extra Help

Eligibility requirements for our plan

- Must have Medicare Part A and Medicare Part B.
- Must reside in the plan's service area: Bronx, Kings, New York, Queens and Westchester counties.
- Must be a United States citizen or lawfully present in the United States.

Which Doctors, Hospitals and Pharmacies can I use?

Elderplan Extra Help (HMO-POS) has a network of doctors, hospitals, pharmacies and other providers. Our plan allows you to see In-Network and Out-of-Network providers based on our expansive benefit offering. Our plan covers services and benefits from any of our network providers listed in our Provider and Pharmacy Directory. Our plan also includes point-of-service coverage for certain services and benefits from any Medicare-certified provider who has not opted out of Medicare. 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 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-POS)		
Monthly Premium (Part D Premium)	$34.70	In addition, you must keep paying your Medicare Part B premium.
Part B Deductible	$0	
Combined Maximum Out - of - Pocket	$7,550 In-Network and Out-of Network Combined	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 limit on in-network and out-of network combined out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your plan premium, and any cost-sharing for your Part D prescription drugs.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need hospital care	Inpatient Hospital Services	You pay per admission: • Days 1–5: $390 copayment each day. • Day 6 and beyond: $0 copayment each day.	Authorization is required.
	Outpatient Hospital Services	20% coinsurance.	
	Ambulatory Surgical Center (ASC)	20% coinsurance.	
You want to see a doctor	Primary Care Providers	$0 copayment for office visits and telehealth services.	Please call your current provider for telehealth services details.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You want to see a doctor *(continued)*	Specialists	**In-Network** $25 copayment for office visits. $10 copayment for telehealth services. **Out-of-Network** $25 copayment for office visits.	Please call your current provider for telehealth services details.
	Nurse Practitioners and Physician Assistants	**In-Network** $25 copayment for office visits. **Out-of-Network** $25 copayment for office visits.	Authorization only required for in-home visits.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You want to see a doctor *(continued)*	Preventive Care	$0 copayment for Annual Physical Exam.	This exam is covered in addition to the "Welcome to Medicare Exam" and Yearly "Wellness" Visit.
		$0 copayment.	Preventive care services may be covered by Medicare during the benefit year.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You want to see a doctor *(continued)*	Preventive Care *(continued)*	• Abdominal aortic aneurysm screening • Alcohol misuse screenings & counseling • Blood-based biomarker test • Cardiovascular disease (behavioral therapy) • Cardiovascular disease screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings - Multi-target stool DNA tests - Screening barium enemas - Screening colonoscopies - Screening fecal occult blood tests - Screening flexible sigmoidoscopies • Depression screenings • Diabetes screenings • Diabetes self-management training • Glaucoma tests • Hepatitis B Virus (HBV) infection screening	

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You want to see a doctor *(continued)*	Preventive Care *(continued)*	• Hepatitis C Screening Test • HIV screening • Lung cancer screenings • Mammograms (screening) • Medicare Diabetes Prevention Program • Nutrition Therapy Services • Obesity screenings and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections (STI) screenings and counseling • Tobacco use cessation counseling • COVID-19 vaccines, Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one time) • Yearly "Wellness" Visit	

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You Need Emergency Care	Emergency Care	$90 copayment for each Medicare-covered emergency room visit.	If you are admitted to the hospital within 24 hours there is no cost share.
	Urgent Care	$35 copayment for office visits. $10 copayment for telehealth services.	Please call your current provider for telehealth services details.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need medical tests	Diagnostic Services/ Labs/Imaging • Medicare-covered Lab Services • Outpatient Blood Services	$0 copayment for each service.	
	Diagnostic Services/ Labs/Imaging • Diagnostic tests and Procedures	$35 copayment for each service.	

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need medical tests *(continued)*	Diagnostic Services/ Labs/Imaging • Outpatient X-rays	$20 copayment for each service.	
	Diagnostic Services/ Labs/Imaging • Therapeutic radiology services (such as radiation treatment for cancer) • Diagnostic Radiological services (such as MRI scans and CT scans)	20% coinsurance for each service.	Authorization is required only for Positron Emission Tomography (PET), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), and CAT Scan (CT).

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Hearing Care	Hearing Exams	$35 copayment for each Medicare-covered diagnostic hearing exams.	
		$0 copayment for one Non-Medicare-covered (Routine) Hearing Exam every 3 years.	
	Hearing Aids	Up to $500 maximum benefit every 3 years for one ear. $0 copayment for Fitting/Evaluation for Hearing Aid every 3 years. This benefit can only be used for one ear.	Authorization is required for hearing aid(s) by a Physician or Specialist.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Dental Care	Preventive Dental Services	$0 for coverage of Supplemental Preventive Dental Services are limited to selected service codes from the categories below In and Out-of-Network combined.	
	Comprehen-sive Dental Services	Coverage of Supplemental Comprehensive Dental Services are limited to selected service codes from the categories below In and Out-of-Network combined.	Supplemental Comprehensive Dental Services. Benefit frequency may be limited per American Dental Association guidelines.
		20% coinsurance for Medicare-covered Comprehensive Dental Services.	

Supplemental Preventive & Comprehensive Dental Services

In-Network and Out-of-Network

Covered Services	Copayment	Frequency
Supplemental Diagnostic & Preventive Dental Services		
Exams		
Periodic Oral Exam	No charge	Once every 6 months
Limited Oral Exam	No charge	Once every 6 months
Comprehensive Oral Exam	No charge	Once every 6 months
Problem-focused Oral Exam	No charge	Once every 6 months
Follow-up Exam	No charge	Once every 6 months
Comprehensive Periodontal Exam	No charge	Once every 6 months
X-Rays		
Complete Series X-rays	No charge	Once every 36 months
Periapical X-ray	No charge	Once every 12 months
Periapical X-ray, each additional film	No charge	Once every 12 months
Occlusal X-ray	No charge	Once every 12 months
2-D Projection X-ray	No charge	Once every 12 months
Bitewing X-ray – single image	No charge	Once every 12 months
Bitewing X-ray – two images	No charge	Once every 12 months
Bitewing X-ray – three images	No charge	Once every 12 months

Bitewing X-ray – four images	No charge	Once every 12 months
Vertical Bitewing X-rays – seven to eight images	No charge	Once every 12 months
Panoramic X-ray	No charge	Once every 12 months
Cephalometric X-ray	No charge	Once every 12 months
2-D Photographic Images	No charge	Once every 12 months
Cleanings		
Prophylaxis (Cleaning) – Adult	No charge	Once every 6 months
Topical Fluoride Application	No charge	Once every 6 months
Supplemental Comprehensive Dental Services		
Restorative Services		
Silver Filling – One Surface	No charge	Once every 24 months, per tooth
Silver Filling – Two Surfaces	No charge	Once every 24 months, per tooth
Silver Filling – Three Surfaces	No charge	Once every 24 months, per tooth
Silver Filling – Four or More Surfaces	No charge	Once every 24 months, per tooth
Tooth-colored Filling – One Surface, Front	No charge	Once every 24 months, per tooth
Tooth-colored Filling – Two Surfaces, Front	No charge	Once every 24 months, per tooth

Tooth-colored Filling – Three Surfaces, Front	No charge	Once every 24 months, per tooth
Tooth-colored Filling – Four or More Surfaces, Front	No charge	Once every 24 months, per tooth
Tooth-colored Crown – Front	No charge	Once every 24 months, per tooth
Tooth-colored Filling – One Surface, Back	No charge	Once every 24 months, per tooth
Tooth-colored Filling – Two Surfaces, Back	No charge	Once every 24 months, per tooth
Tooth-colored Filling – Three Surfaces, Back	No charge	Once every 24 months, per tooth
Tooth-colored Filling – Four or More Surfaces, Back	No charge	Once every 24 months, per tooth
Inlay – Metallic, One Surface	$150	Once every 60 months, per tooth
Inlay – Metallic, Two Surfaces	$150	Once every 60 months, per tooth
Inlay – Metallic, Three or More Surfaces	$150	Once every 60 months, per tooth
Onlay – Metallic, Two Surfaces	$150	Once every 60 months, per tooth
Inlay – Porcelain/Ceramic, Two Surfaces	$150	Once every 60 months, per tooth

Inlay – Porcelain/Ceramic, Three or More Surfaces	$150	Once every 60 months, per tooth
Crown – Resin-Based Composite	$150	Once every 60 months, per tooth
Crown – 3/4 Resin-Based Composite	$150	Once every 60 months, per tooth
Crown – Resin with High Noble Metal	$150	Once every 60 months, per tooth
Crown – Composite/Resin with Base Metal	$150	Once every 60 months, per tooth
Crown – Resin with Noble Metal	$150	Once every 60 months, per tooth
Crown – Porcelain/Ceramic Substrate	$150	Once every 60 months, per tooth
Crown – Porcelain Fused to High Noble Metal	$150	Once every 60 months, per tooth
Crown – Porcelain Fused to Predominantly Base Metal	$150	Once every 60 months, per tooth
Crown – Porcelain Fused to Noble Metal	$150	Once every 60 months, per tooth
Crown – Porcelain Fused to Titanium/Titanium Alloys	$150	Once every 60 months, per tooth
Crown – Full Cast High Noble Metal	$150	Once every 60 months, per tooth
Crown – Full Cast Predominantly Base Metal	$150	Once every 60 months, per tooth

Crown – Full Cast Noble Metal	$150	Once every 60 months, per tooth
Re-cement or Re-bond Inlay, Onlay or Veneer	No charge	Once every 6 months, per tooth
Re-cement or Re-bond Crown	No charge	Once after 6 months, per tooth
Reattachment of Tooth Fragment	No charge	Once every 6 months, per tooth
Stainless Steel Crown, Baby Tooth	No charge	Once every 60 months, per tooth
Stainless Steel Crown, Adult Tooth	No charge	Once every 60 months, per tooth
Pin Retention	No charge	Once every 60 months, per tooth
Post and Core in Addition to Crown	$50	Once every 60 months, per tooth
Each Additional Indirectly Fabricated Post	$50	Once every 60 months, per tooth
Prefabricated Post and Core in Addition to Crown	$50	Once every 60 months, per tooth
Endodontic Services		
Therapeutic Pulpotomy	No charge	Once per lifetime, per tooth
Pulpal Therapy, Front Tooth	No charge	Once per lifetime, per tooth

Pulpal Therapy, Back Tooth	No charge	Once per lifetime, per tooth
Root Canal Therapy, Front Tooth	No charge	Once per lifetime, per tooth
Root Canal Therapy, Bicuspid Tooth	No charge	Once per lifetime, per tooth
Root Canal Therapy, Back Tooth	$40	Once per lifetime, per tooth
Retreatment of Root Canal Therapy, Front Tooth	No charge	Once per lifetime, per tooth
Retreatment of Previous Root Canal Therapy, Bicuspid Tooth	No charge	Once per lifetime, per tooth
Retreatment of Root Canal Therapy, Back Tooth	$40	Once per lifetime, per tooth
Apicoectomy, Front Tooth	$40	Once per lifetime, per tooth
Apicoectomy, Bicuspid Tooth – First Root	$40	Once per lifetime, per tooth
Apicoectomy, Back Tooth – First Root	$40	Once per lifetime, per tooth
Apicoectomy, Each Additional Root	$40	Once per lifetime, per tooth
Retrograde Filling – Per Root	$40	Once per lifetime, per tooth

Surgical Exposure of Root Surface – Anterior	$40	Once per lifetime, per tooth
Surgical Exposure of Root Surface – Premolar	$40	Once per lifetime, per tooth
Surgical Exposure Of Root Surface – Molar	$40	Once per lifetime, per tooth
Periodontic Services		
Gum treatments	$40	Once per 36 months, per quadrant
Gum and Bone Treatment	$150	Once per 60 months, per quadrant
Gum and Bone Treatment	$150	Once per 60 months, per quadrant
Deep Cleaning	No Charge	Once per 36 months, per quadrant
Deep Cleaning	No Charge	Once per 36 months, per quadrant
Deep Cleaning – To Help Dentist Evaluate Mouth	No Charge	Once per 36 months
Deep Cleaning – Cleaning After Gum Treatment	No Charge	Once per 36 months
Maxillofacial Services – Removable		
Full Upper Denture	$150	Once per 60 months
Full Lower Denture	$150	Once per 60 months

Immediate Denture – Maxillary	$150	Once per 60 months
Immediate Denture – Mandibular	$150	Once per 60 months
Partial Upper Denture – Resin Based	$150	Once per 60 months
Partial Lower Denture – Resin Based	$150	Once per 60 months
Partial Upper Denture – Cast Metal	$150	Once per 60 months
Partial Lower Denture – Cast Metal	$150	Once per 60 months
One-Sided Partial Denture – Cast Metal, Upper	$150	Once per 60 months
One-Sided Partial Denture – Cast Metal, Lower	$150	Once per 60 months
Partial Denture Made for One Side of Mouth – Flexible Plastic Material	$150	Once per 60 months
Partial Denture Made for One Side of Mouth – Plastic Material	$150	Once per 60 months
Full Upper Denture Adjustment	No Charge	Covered
Full Lower Denture Adjustment	No Charge	Covered

Partial Upper Denture Adjustment	No Charge	Covered
Partial Lower Denture Adjustment	No Charge	Covered
Denture Repair – Lower Denture	No Charge	Once per 12 months
Denture Repair – Upper Denture	No Charge	Once per 12 months
Replace Missing or Broken Tooth, Full Denture	No Charge	Once per 12 months
Partial Denture Repair – Repair of Plastic Material on Lower Partial	No Charge	Once per 12 months
Partial Denture Repair of Plastic Material on Upper Partial	No Charge	Once per 12 months
Repair Cast Frame, Partial Denture, Mandibular	No Charge	Once per 12 months
Repair Cast Frame, Partial Denture, Maxillary	No Charge	Once per 12 months
Repair/Replace Broken Clasp, per Tooth	No Charge	Once per 12 months
Replace Broken Teeth, per Tooth	No Charge	Once per 12 months
Add Tooth to Existing Partial Denture	No Charge	Once per 12 months

Add Clasp to Existing Partial Denture	No Charge	Once per 12 months
Rebase Full Upper Denture	No Charge	Once per 12 months
Rebase Full Lower Denture	No Charge	Once per 12 months
Rebase Partial Upper Denture	No Charge	Once per 12 months
Rebase Partial Lower Denture	No Charge	Once per 12 months
Reline Full Upper Denture, in Office	No Charge	Once per 12 months
Reline Full Lower Denture, in Office	No Charge	Once per 12 months
Reline Partial Upper Denture, in Office	No Charge	Once per 12 months
Reline Partial Lower Denture, in Office	No Charge	Once per 12 months
Reline Full Upper Denture, in Lab	No Charge	Once per 12 months
Reline Full Lower Denture, in Lab	No Charge	Once per 12 months
Reline Partial Upper Denture, in Lab	No Charge	Once per 12 months
Reline Partial Lower Denture, in Lab	No Charge	Once per 12 months
Overdenture, Full Upper	$150	Once per 60 months

Overdenture, Partial Upper	$150	Once per 60 months
Overdenture, Full Lower	$150	Once per 60 months
Overdenture, Partial Lower	$150	Once per 60 months
Prosthodontic Services		
Pontic – High Noble Metal	$150	Once per 60 months, per tooth
Pontic – Cast Predominantly Base Metal	$150	Once per 60 months, per tooth
Pontic – Cast Noble Metal	$150	Once per 60 months, per tooth
Pontic – Porcelain Fused to High Noble Metal	$150	Once per 60 months, per tooth
Pontic – Porcelain Fused to Predominantly Base Metal	$150	Once per 60 months, per tooth
Pontic – Porcelain Fused to Noble Metal	$150	Once per 60 months, per tooth
Pontic – Porcelain Fused to Titanium	$150	Once per 60 months, per tooth
Pontic – Resin with High Noble Metal	$150	Once per 60 months, per tooth
Pontic – Resin with Predominantly Base Metal	$150	Once per 60 months, per tooth
Pontic – Resin with Noble Metal	$150	Once per 60 months, per tooth
Retainer – Cast Metal for Resin Bonded	$150	Once per 60 months, per tooth

Retainer Onlay – Cast High Nobel Metal, Two Surface	$150	Once per 60 months, per tooth
Retainer Crown – Resin Crown	$150	Once per 60 months, per tooth
Retainer Crown – Resin with High Noble Metal	$150	Once per 60 months, per tooth
Retainer Crown – Resin with Predominantly Base Metal	$150	Once per 60 months, per tooth
Retainer Crown – Resin with Noble Metal	$150	Once per 60 months, per tooth
Retainer Crown – Porcelain/ Ceramic	$150	Once per 60 months, per tooth
Retainer Crown – Porcelain Fused to High Noble Metal	$150	Once per 60 months, per tooth
Retainer Crown – Porcelain Fused to Predominantly Base Metal	$150	Once per 60 months, per tooth
Retainer Crown – Porcelain Fused to Noble Metal	$150	Once per 60 months, per tooth
Retainer Crown - Porcelain/ Titamium and Alloys	$150	Once per 60 months, per tooth
Retainer Crown – Full Cast High Noble Metal	$100	Once per 60 months, per tooth
Retainer Crown – Full Cast Predominantly Base Metal	$100	Once per 60 months, per tooth

Retainer Crown – Full Cast Noble Metal	$100	Once per 60 months, per tooth
Re-cement or Re-bond, per Unit	No Charge	Covered
Oral and Maxillofacial Surgery		
Extraction – Erupted or Exposed Root	No Charge	Once per lifetime, per tooth
Surgical Removal – Erupted Tooth	No Charge	Once per lifetime, per tooth
Removal of Impacted Tooth – Soft	No Charge	Once per lifetime, per tooth
Removal of Impacted Tooth – Partially Bony	$100	Once per lifetime, per tooth
Removal of Impacted Tooth – Comp Bony	$100	Once per lifetime, per tooth
Removal of Impacted Tooth – Completely Bony, with Unusual Surgical Complications	$100	Once per lifetime, per tooth
Surgical Remove Residual Roots	$100	Once per lifetime, per tooth
Oralantral Fistula Closure	$100	Once per lifetime, per tooth
Surgical Access of an Unerupted Tooth	$100	Once per lifetime, per tooth

Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$100	Once per lifetime, per tooth
Alveoloplasty with Extraction – per Quad	No Charge	Once per lifetime, per tooth
Alveoloplasty – per Quad	No Charge	Once per 12 months, per quadrant
Vestibuloplasty – Ridge Extension (Second Epitheliazation)	$100	Covered
Excision of Benign Lesion of up 1.25 cm	$100	Covered
Excision of Benign Lesion Greater than 1.25 cm	$100	Covered
Excision of Malignant Tumor – Lesion Diameter up to 1.25 cm	$100	Covered
Excision of Malignant Tumor – Lesion Diameter Greater than 1.25 cm	$100	Covered
Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm	$100	Covered

Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter Greater than 1.25 cm	$100	Covered
Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm	$100	Covered
Removal of Benign Nonodontogenic cyst or tumor – Lesion Diameter Greater than 1.25 cm	$100	Covered
Removal of Lateral Exostosis – Maxilla or Mandible	$100	Covered
Removal of Torus Mandibularis	$100	Covered
Incision and Drainage of Abscess – Intraoral Soft Tissue	$100	Covered
Incision and Drainage of Abscess – Extraoral Soft Tissue	$100	Covered
Buccal/Labial Frenectomy (Frenulectomy)	$100	Covered
Lingual Frenectomy (Frenulectomy)	$100	Covered

Excision of Hyperplastic Tissue – per Arch	$100	Covered
Excision of Pericoronal Gingiva	$100	Covered
Adjunctive General Services		
Palliative (Emergency) Treat	No charge	Covered
Local Anesthesia not in Conjunction with Operative or Surgical Procedure	No charge	Covered
Regional Block Anesthesia	No charge	Covered
Trigeminal Division Block Anesthesia	No charge	Covered
Local Anesthesia	No charge	Covered
Consultation – Diagnostic Service Provided by Dentist or Physician Other than Requesting Dentist or Physician	No charge	Covered
Office Visit for Observation (During Regularly Scheduled Hours) – No Other Services Performed	No charge	Covered
Occlusal Adjustment – Limited	No charge	Covered
Occlusal Adjustment – Complete	No charge	Covered

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Eye Care	Vision Exams	$25 copayment for Medicare-covered eye exams.	
		$0 Copayment for one routine eye exam for eyewear.	You may receive one Eye Exam every year.
	Vision Eyewear	$0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.	
		$0 copayment for Non-Medicare-covered eyewear (Routine) up to $150 annual maximum every year.	Includes contact lenses and eyeglasses.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Mental Health Care	Inpatient Mental Health	You pay per admission: • Days 1–5: $350 copayment each day. • Day 6 and beyond: $0 copayment each day.	Authorization is required.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Mental Health Care *(continued)*	Outpatient Mental Health	**In-Network** Mental Health Individual Sessions:$20 Copayment for each office session. Mental Health Group Sessions:$5 Copayment for each office session. $10 Copayment for telehealth services. **Out-of-Network** Mental Health Individual Sessions:$20 Copayment for each office session. Mental Health Group Sessions:$5 Copayment for each office session.	Please call your current provider for telehealth services details.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Mental Health Care *(continued)*	Outpatient Mental Health *(continued)*	**In-Network** Psychiatric Services Individual Sessions:$25 Copayment for each office session. Psychiatric Services Group Sessions:$5 Copayment for each office session. $10 Copayment for telehealth services. **Out-of-Network** Psychiatric Services Individual Sessions:$25 Copayment for each office session. Psychiatric Services Group Sessions:$5 Copayment for each office session.	Please call your current provider for telehealth services details.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Rehabili-tative or Skilled Nursing Care	Skilled Nursing Facility	You pay per admission: Days 1–20: $0 copayment per day. Days 21–100: $196 copayment per day. Days 101 and beyond: you pay all cost.	The plan covers up to 100 days each benefit period, a 3-day prior hospital stay is required. Authorization is required.
You need Outpatient Therapy	Physical Therapy	**In-Network** $25 copayment for each visit. **Out-of-Network** $25 copayment for each visit.	Authorization is required.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need help getting to health services	Ambulance copayment	$215 for each one-way trip.	Authorization is only required for non-emergency services.
	Transportation	$0 copayment. You may take up to 32 one-way trips for medical related purposes every year.	You may take a taxi, bus, subway or van.
You need drugs to treat your illness or condition	Medicare Part B Drugs	20% coinsurance for Medicare Part B Prescription Drugs. Up to $35 for Medicare Part B Insulin Drugs.	Some Medicare Part B Prescription Drugs may be subject to step therapy requirements. Authorization may be required for certain drugs.

Medicare Part D

If you qualify for Low-Income subsidy (also called "Extra Help"), you may not pay the amounts listed in the table below for your Part D prescription drugs. The exact amount you pay may vary depending on the amount of Extra Help you receive.

Part D Premium	$34.70 per month.
Part D Deductible	Tier 1, 2, and 3 Drugs: Part D deductible is $0. Tier 4 and 5 Drugs: Part D deductible is $545. Members pay the full cost of their drugs until their $545 deductible is met, then the cost-shares are applied in the initial coverage stage.

Medicare Part D

Part D Deductible & Initial Coverage Stage

Tier: Tier Name	**Part D Deductible**	Initial Coverage Stage		
		Retail Pharmacy Cost share (30-day supply)*Ω	Retail Pharmacy Cost share (Up to 90-day supply)^†Ω	Mail Order Pharmacy Cost share (Up to 90-day supply)†Ω
Tier 1: Preferred Generic Drugs	$0	$4 Copayment	$12 Copayment	$8 Copayment
Tier 2: Generic Drugs		$10 Copayment	$30 Copayment	$20 Copayment
Tier 3: Preferred Brand Drugs		$47 Copayment	$141 Copayment	$94 Copayment
Tier 4: Non-preferred Drugs	$545	$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 (31-day), and Out-of-network cost share.
^60-Day supply is also available for Standard retail (in-network).
†NDS – Non-Extended Days Supply. Certain Specialty drugs will be limited up to a 30-day supply per fill.

Medicare Part D

Ω – You will not pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter the cost-sharing for Part B and D drugs, even if you have not paid your deductible.

Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap stage).

Coverage Gap Stage

You pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs.	If you receive Extra Help, you will not enter the Coverage Gap Stage. Instead, you will continue to pay the Initial Coverage Stage cost-sharing until the Catastrophic Stage.

You stay in this stage until your "out-of-pocket costs" (your payments) reach a total of $8,000. This amount and rules for counting costs toward this amount have been set by Medicare.

Catastrophic Coverage Stage

Once your "out-of-pocket costs" (your payments) reach a total of $8,000, you stay in this payment stage until the end of the calendar year.

Catastrophic Coverage	During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Other Covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Medical Equipment and Supplies	Diabetic Supplies	$0 copayment for Medicare-Covered Diabetic Supplies.	Diabetic Test Strips and Blood Glucose Meters are limited to specific manufacturers: Abbott Diabetes Care and Ascensia Diabetes Care.
	Durable Medical Equipment (like wheelchairs or oxygen)	20% coinsurance for Medicare-covered Durable Medical Equipment (DME).	Authorization is required for certain items.
	Medical Supplies	20% coinsurance for Medical Supplies.	Authorization is required.
	Prosthetics (artificial limbs or braces)	20% coinsurance for Prosthetic Devices.	Authorization is required.

Other Covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Rehabilitation Services	Physical Therapy, Occupational Therapy, Speech Language Therapy	**In-Network** $25 copayment for each visit. **Out-of-Network** $25 copayment for each visit.	Authorization is required.
	Cardiac Rehabilitation	$10 copayment for Cardiac Rehabilitation Services.	Authorization is required.
	Pulmonary Rehabilitation	$15 copayment for Pulmonary Rehabilitation Services.	Authorization is required.

More benefits with your plan	
Expanded Acupuncture Services	$0 copayment per visit. You may receive up to 20 visits per year for the following services: • Acupuncture • Cupping/Moxa • Acupressure • Tui Na • Gua Sha • Reflexology • Infrared Therapy
Brain Games with BrainHQ®	There is no copayment or coinsurance for BrainHQ®. Members will have access to an online memory fitness program to improve brain function through games, puzzles and other fun exercises.
Flex Card	There is no coinsurance or copayment for Flex Card. You will receive a $500 allowance to use in 2024 on out-of-pocket costs for dental, vision, hearing, and/or fitness services. Any unused benefit dollars will expire at the end of the calendar year or if you disenroll from the plan.

More benefits with your plan	
OTC	You may purchase up to $140 every quarter of eligible OTC items on an OTC card provided by Elderplan.
OTC + Grocery + Meals	For eligible members (with certain chronic conditions) the Special Supplemental Benefits for the Chronically Ill combines with the OTC benefit to cover certain grocery items and meals as a part of the quarterly OTC allowance.
Routine Podiatry Services	**In-Network** $25 copayment per visit. You may receive up to 10 visits per year. **Out-of-Network** $25 copayment per visit. You may receive up to 10 visits per year.
Silver&Fit® Fitness Program	The Silver&Fit® Healthy Aging and Exercise program provides Elderplan members access to a Fitness Center membership at a location from the participating Network and the option to choose a Home Fitness kit including options like a wearable fitness tracker or a strength kit. Also available, on-demand workout classes and one-on-one Healthy Aging Coaching sessions and the Well-Being Club.

More benefits with your plan	
Teladoc®	At $0 cost share, Teladoc® connects you with board-certified doctors 24 hours a day, 7 days a week for video or phone chat using your smartphone, tablet or computer. These doctors can help diagnose, treat and even write prescriptions for a variety of non-emergency conditions.
Worldwide Emergency/ Emergency Transportation / Urgent Coverage	$0 copayment for Worldwide Emergency Coverage / Emergency Transportation / Urgent Coverage. 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:

Elderplan, Inc.
ATTN Civil Rights Coordinator
55 Water Street
New York NY 10041

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

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-353-3765 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-353-3765 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Simplified: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-353-3765 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Traditional: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-353-3765 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-353-3765 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-353-3765 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-353-3765 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-353-3765 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-353-3765 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-353-3765 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة فوري، ليس عليك سوى الاتصال بنا على 1-800-353-3765 (TTY:711). سيقوم شخص ما يتحدث العربية مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-353-3765 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-353-3765 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-353-3765 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-353-3765 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-353-3765 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-353-3765 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Albanian: Ne ofrojmë shërbime interpretimi pa pagesë për t'ju përgjigjur çdo lloj pyetjeje që mund të keni rreth planit tonë të shëndetit ose të mjekimit. Për t'u lidhur me një interpret, telefononi në 1-800-353-3765 (TTY: 711). Një shqip folës mund t'ju ndihmojë. Ky shërbim është pa pagesë.

Bengali: আমাদের স্বাস্থ্য বা ওষুধপত্র বিষয়ক পরিকল্পনা সম্পর্কিত আপনার যে কোনো প্রশ্নের উত্তর দেওয়ার জন্য আমাদের বিনামূল্যে দোভাষী পরিষেবা রয়েছে৷ একজন দোভাষী পেতে, আমাদের কেবল 1-800-353-3765 (TTY: 711) নম্বরে কল করুন৷ বাংলা বলতে পারেন এমন কেউ আপনাকে সাহায্য করতে পারবেন৷ পরিষেবাটি বিনামূল্যে৷

Greek: Διαθέτουμε υπηρεσία δωρεάν διερμηνείας προκειμένου να απαντούμε σε οποιεσδήποτε απορίες σας σχετικά με το πρόγραμμα υγείας ή φαρμάκων που προσφέρουμε. Προκειμένου να χρησιμοποιήσετε την υπηρεσία διερμηνείας, επικοινωνήστε μαζί μας καλώντας το 1-800-353-3765 (TTY: 711). Θα λάβετε βοήθεια από ένα άτομο που μιλά ελληνικά. Αυτή είναι μια υπηρεσία που παρέχεται δωρεάν.

Yiddish: מיר האבן אומזיסטע דאלמעטשער סערוויסעס צו ענטפערן סיי וועלכע פראגעס וואס איר קענט מעגליך האבן וועגן אונזער העלט אדער דראג פלאן. צו באקומען א דאלמעטשער, רופט אונז אויף 1-800-353-3765 (TTY:711) איינער וואס רעדט אידיש/שפראך קען אייך העלפן. דאס איז אן אומזיסטע סערוויס.

Urdu: ہماری صحت یا دوا کے پلان کے بارے میں آپ کے کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مفت مترجم کی خدمات موجود ہیں۔ مترجم حاصل کرنے کے لیے، ہمیں بس 1-800-353-3765 (TTY: 711) پر کال کریں۔ اردو بولنے والا کوئی شخص آپ کی مدد کر سکتا ہے۔ یہ ایک مفت خدمت ہے۔

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-353-3765**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **www.elderplan.org** or call **1-800-353-3765** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on **January 1, 2025**.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.
- ☐ Your medical and prescription coverage were reviewed against your current insurance coverage. You will become a member of Elderplan upon enrollment verification and no longer have coverage with your current plan.

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.