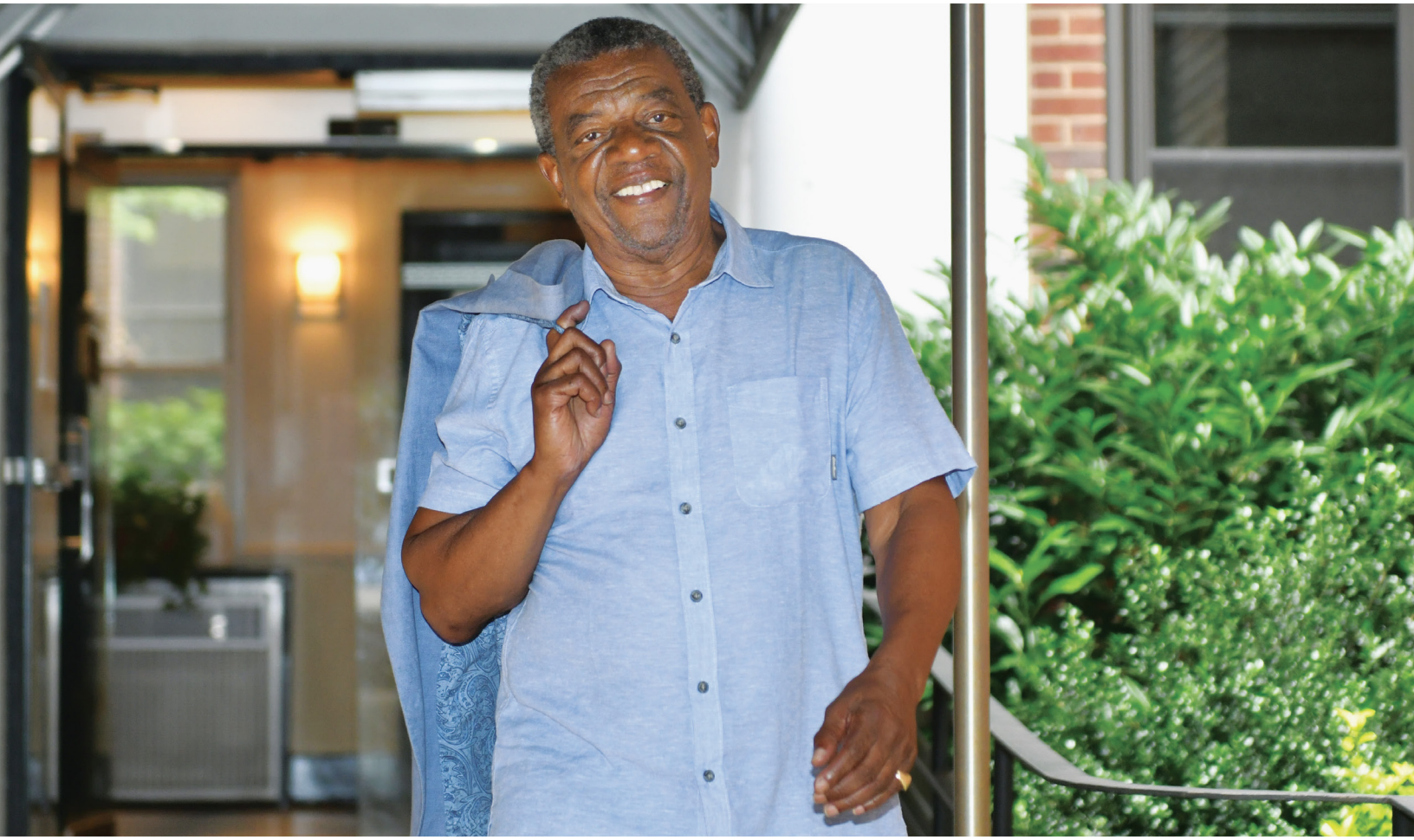
2022

elderplan®

Caring every minute, every day.



Summary of Benefits

Elderplan Extra Help (HMO)

January 1, 2022 to December 31, 2022

H3347_EP17050_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)**

January 1, 2022 – December 31, 2022

Bronx, Kings, New York, Queens, and Westchester

About Elderplan

Elderplan is a not-for-profit organization founded right here in New York. Our primary objective is ensuring that members of our community receive the care and support they deserve. That's why we offer a variety of Medicare Advantage plans tailored to fit the changing needs of Medicare and dual Medicare and Medicaid beneficiaries at every level of health.

Elderplan is a member of MJHS Health System, a not-for-profit organization founded by Four Brooklyn Ladies in 1907 based on the core values of compassion, dignity and respect.

Elderplan is proud to care for people of every race, ethnicity, faith, national origin, gender identity or expression, sexual orientation or military status.

Elderplan Extra Help (HMO)

Plan Overview

Making sure you receive the care you need is important to us. Making sure it's affordable is important too. That's why we designed a plan for Medicare beneficiaries, which offers a little extra help in paying for your health coverage. You get the health care you need with a low premium and low co-pays. In addition to medical and hospital coverage, our members with Low Income Subsidy (LIS) will also experience additional savings on prescription drug coverage. Plus, you will enjoy an over-the-counter (OTC) benefit, which includes health-related and select grocery items* you can purchase at a store or order online, as well as home delivered meals. The plan also provides comprehensive dental and transportation to medical appointments. If by now it is not clear that our main goal is keeping you healthy and happy, you should also know we offer a Wellness Incentive program, which rewards you for receiving preventive screenings and immunizations. And because we care about your physical and mental well-being, we provide a fitness benefit (that allows you to join classes from home or work out at the gym) and the BrainHQ® Memory Fitness Program.

When you pay less on health care coverage, you have more to spend on things you enjoy.

Because we care. Every minute. Every day.

Contents

Benefits at a Glance

Part B Deductible	**$0**
Doctor Visits (Primary Care)	
Acupuncture	
Transportation	
Routine Vision	
Routine Hearing	
Silver&Fit® Fitness Program	
Brain Games with BrainHQ®	
24/7 Access to Care with Teladoc®	
Specialist Care	**$35**
Routine Podiatry	
Over-the-Counter (OTC) Benefits	up to **$60** every quarter

NEW! Use your OTC benefit to purchase groceries and meals too!*

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

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 2022 Elderplan Extra Help (HMO) 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. 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), 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

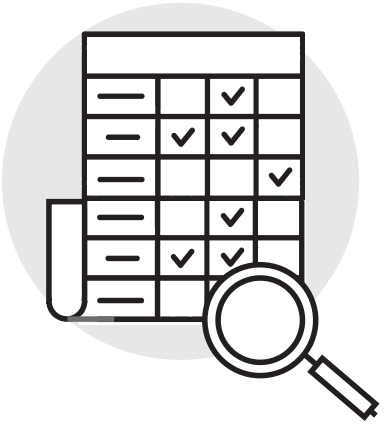
You have choices about how to get your Medicare Benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the federal government.
- 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

- 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) 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 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 Premium (Part D Premium)	$42.00	In addition, you must keep paying your Medicare Part B premium.
Part B Deductible	$0	
Maximum Out-of-Pocket	$7,550	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 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 each visit.	This benefit is also available through Telehealth. Please call your current provider for 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	$35 copayment for office visits. $10 copayment for telehealth services.	This benefit is also available through Telehealth. Please call your current provider for details.
	Nurse Practitioners and Physician Assistants	$35 copayment for office visits.	Authorization only required for in-home visits.
	Preventive Care	$0 copayment for Annual Physical Exam.	This exam is covered in addition to the "Welcome to Medicare Exam" and "Annual 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 • Annual "wellness" visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screening • 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 screening • 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 • HIV screening • Lung cancer screenings • Medical nutrition therapy services • Obesity screenings and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections (STI) screenings and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • COVID-19 vaccines, Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one time)	

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.	This benefit is also available through Telehealth. Please call your current provider for 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.	
	Diagnostic Services/ Labs/Imaging • Outpatient X-rays	$20 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 • 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, limited to selected service codes from the categories below.	
	Comprehen-sive Dental Services	Coverage of Supplemental Comprehensive Dental Services is limited to select service codes from the categories below.	Supplemental Comprehensive Dental Services. Benefit frequency may be limited per American Dental Association guidelines.
		20% coinsurance for Medicare-covered Comprehensive Dental Services.	

Diagnostic & Preventive Services		
Covered Services	**Copayment**	**Frequency**
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
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

Diagnostic & Preventive Services *(continued)*		
Covered Services	**Copayment**	**Frequency**
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
Prophylaxis (Cleaning) – Adult	No charge	Once every 6 months
Prophylaxis (Cleaning) – Child	No charge	Once every 6 months
Comprehensive Services		
Restorative Services		
Covered Services	**Copayment**	**Frequency**
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

Restorative Services *(continued)*		
Covered Services	**Copayment**	**Frequency**
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

Restorative Services *(continued)*		
Covered Services	**Copayment**	**Frequency**
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 – Composite/Resin with noble metal	$150	Once every 60 months, per tooth
Crown – Porcelain/ Ceramic Substrate	$150	Once every 60 months, per tooth

Restorative Services *(continued)*		
Covered Services	**Copayment**	**Frequency**
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 – 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 every 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

Restorative Services *(continued)*		
Covered Services	**Copayment**	**Frequency**
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		
Covered Services	**Copayment**	**Frequency**
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

Endodontic Services *(continued)*		
Covered Services	**Copayment**	**Frequency**
Retreatment of Root Canal Therapy, Front Tooth	No charge	Once per lifetime, per tooth
Retreatment of 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
Periradicular Surgery without Apicoectomy	$40	Once per lifetime, per tooth
Retrograde Filling – Per Root	$40	Once per lifetime, per tooth
Gingivectomy – Four or More Teeth	$40	Once per 36 months, per quadrant

Endodontic Services *(continued)*		
Covered Services	**Copayment**	**Frequency**
Osseous Surgery – Four or More Teeth – Same quadrant	$150	Once per 60 months, per quadrant
Osseous Surgery – One to Three Teeth – Same quadrant	$150	Once per 60 months, per quadrant
Periodontal Scaling and Root Planing, Four or More Teeth	No charge	Once per 36 months, per quadrant
Periodontal Scaling and Root Planing, One to Three Teeth	No charge	Once per 36 months, per quadrant
Full Mouth Debridement	No charge	Once per 36 months
Periodontal Maintenance	No charge	Once per 36 months
Maxillofacial Services – Removable		
Covered Services	**Copayment**	**Frequency**
Full Upper Denture	$150	Once per 60 months
Full Lower Denture	$150	Once per 60 months
Full Upper Immediate Denture	$150	Once per 60 months
Full Lower Immediate Denture	$150	Once per 60 months
Partial Upper Denture – Resin Based	$150	Once per 60 months

Maxillofacial Services – Removable *(continued)*		
Covered Services	**Copayment**	**Frequency**
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
Full Upper Denture Adjustment	No charge	
Full Lower Denture Adjustment	No charge	
Partial Upper Denture Adjustment	No charge	
Partial Lower Denture Adjustment	No charge	
Repair Broken Denture, Full Denture	No charge	Once per 12 months
Replace Missing or Broken Tooth, Full Denture	No charge	Once per 12 months

Maxillofacial Services – Removable *(continued)*		
Covered Services	**Copayment**	**Frequency**
Repair Denture Base, Partial Denture	No charge	Once per 12 months
Repair Cast Frame, Partial Denture	No charge	Once per 12 months
Repair/Replace Broken Clasp, per Tooth	No charge	Once per 12 months
Replace Broken Tooth – Partial Denture	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

Maxillofacial Services – Removable *(continued)*		
Covered Services	**Copayment**	**Frequency**
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 – Fixed		
Covered Services	**Copayment**	**Frequency**
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 – 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

Prosthodontic Services – Fixed *(continued)*		
Covered Services	**Copayment**	**Frequency**
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 – Full Cast High Noble Metal	$100	Once per 60 months, per tooth

Prosthodontic Services – Fixed *(continued)*		
Covered Services	**Copayment**	**Frequency**
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	

Oral Surgery & Maxillofacial Services		
Covered Services	**Copayment**	**Frequency**
Routine Extraction	No charge	Once per lifetime, per tooth
Surgical Extraction	No charge	Once per lifetime, per tooth
Extraction – Soft Tissue Impaction	No charge	Once per lifetime, per tooth
Extraction – Partial Bony Impaction	$100	Once per lifetime, per tooth
Extraction – Full Bony Impaction	$100	Once per lifetime, per tooth
Extraction – Full Bony with Complications	$100	Once per lifetime, per tooth
Removal of Roots	$100	Once per lifetime, per tooth

Oral Surgery & Maxillofacial Services *(continued)*		
Covered Services	**Copayment**	**Frequency**
Oroantral Fistula Closure	$100	Once per lifetime, per tooth
Exposure of Unerupted Tooth	$100	Once per lifetime, per tooth
Mobilization of Erupted or Malpositioned Tooth to Help Eruption	$100	Once per lifetime, per tooth
Alveoloplasty, with Extraction	No charge	Once per lifetime, per quadrant
Alveoloplasty, without Extraction	No charge	Once per 12 months, per quadrant
Vestibuloplasty	$100	
Removal of Benign Lesion <1.25 cm	$100	
Removal of Benign Lesion >1.25 cm	$100	
Removal of Malignant Lesion <1.25 cm	$100	
Removal of Malignant Lesion >1.25 cm	$100	
Removal of Benign Cyst < 1.25 cm	$100	

Oral Surgery & Maxillofacial Services *(continued)*		
Covered Services	**Copayment**	**Frequency**
Removal of Benign Cyst >1.25 cm	$100	
Removal of Benign Non-tooth Structured Cyst <1.25 cm	$100	
Removal of Benign Non-tooth Structured Cyst >1.25 cm	$100	
Removal of Lateral Exostosis (Upper or Lower)	$100	
Removal of Tori on Lower Jaw	$100	
Incision and Drainage, Intraoral	$100	
Incision and Drainage, Extraoral	$100	
Frenectomy	$100	
Removal of Hyperplastic Tissue	$100	
Removal of Pericoronal Gingiva	$100	

Adjunctive General Services		
Covered Services	**Copayment**	**Frequency**
Emergency Treatment	No charge	
Local Anesthesia, not in Conjunction with Surgical or Operative Procedure	No charge	
Regional Block – Local Anesthesia	No charge	
Trigeminal Division Block Anesthesia	No charge	
Local Anesthesia, in Conjunction with Surgical or Operative Procedure	No charge	
Specialist Consultation	No charge	
Office Visit for Observation During Regular Office Hours	No charge	
Occlusal Adjustment – Limited	No charge	
Occlusal Adjustment – Complete	No charge	

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.
	Outpatient Mental Health	Mental Health Individual Sessions: $20 Copayment for each office session. $10 Copayment for telehealth services. Mental Health Group Sessions: $5 Copayment for each office session. $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 Mental Health Care *(continued)*	Outpatient Mental Health *(continued)*	Psychiatric Services Individual Sessions: $25 Copayment for each office session. $10 Copayment for telehealth services. Psychiatric Services Group Sessions: $5 Copayment for each office session. $10 Copayment for telehealth services.	Please call your current provider for telehealth services details.
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: $184 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.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Outpatient Therapy	Physical Therapy	$35 copayment for each visit.	Authorization is required.
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 8 one-way trips for medical related purposes every quarter.	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.	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	$42.00 per month
Part D Deductible	Tier 1, 2, and 3 Drugs: Part D deducible is $0. Tier 4 and 5 Drugs: Part D deducible is $480. Members pay the full cost of their drugs until their $480 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)*	Retail Pharmacy Cost share (90-day supply)^†	Mail Order Pharmacy Cost share (90-day supply)†
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	$480	$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	
Once your total drug costs have reached $4,430, 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 $7,050. 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 $7,050, you stay in this payment stage until the end of the calendar year.	
Catastrophic Coverage Cost-Sharing	You pay either a coinsurance or copayment, whichever is larger:
For **Generic Drugs** (including brand drugs treated as generic):	$3.95 copayment - or - 5% coinsurance
For **All Other Drugs**:	$9.85 copayment - or - 5% coinsurance

Other Covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
	Diabetic Supplies	$0 copayment for Medicare-Covered Diabetes Supplies.	Diabetic Test Strips and Blood Glucose Meters are limited to specific manufacturers: Abbott Diabetes Care and Ascensia Diabetes Care.
You need Medical Equipment and Supplies	Durable Medical Equipment (like wheelchairs or oxygen)	20% coinsurance for Medicare-covered Durable Medical Equipment (DME).	Authorization is only 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	$35 copayment for each visit.	Authorization is required.
	Cardiac Rehabilitation	$10 copayment for Cardiac Rehabilitation Services.	Authorization is required.
	Pulmonary Rehabilitation	$30 copayment for Pulmonary Rehabilitation Services.	Authorization is required.

More benefits with your plan	
Acupuncture Services	$0 copayment per visit. You may receive up to 20 visits per year.
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.
OTC	You may purchase up to $60 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 (grocery benefit) combines with the OTC benefit to cover certain grocery items and meals as a part of the monthly OTC allowance.

More benefits with your plan	
Routine Podiatry Services	$35 copayment per visit. You may receive up to 12 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, digital workout classes and one-on-one Healthy Aging Coaching sessions by phone with a trained health coach.
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.

More benefits with your plan

Worldwide Emergency/ Urgent Care	$65 copayment for Worldwide Emergency/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:

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)।

(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).

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

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. 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.

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, 2023**.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory.)

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.