2025

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Leading the way to great care.℠

Summary of Benefits

Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP)

January 1, 2025 to December 31, 2025

H3347_EP17719_M

Summary of Benefits – **Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) 2025**

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

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Summary of Benefits

for **Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP)**

January 1, 2025 – December 31, 2025

Bronx, Kings, Nassau, New York, Queens, and Westchester

About Elderplan

Elderplan is a Medicare Advantage plan, which is a proud part of the MJHS Health System family. Both Elderplan and MJHS are not-for-profit organizations that share the same core values of compassion, dignity and respect.

Elderplan has a rich history of caring for at-risk New Yorkers of all backgrounds. That's why we understand that 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, we are ***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.

In addition, an advantage to our members of Elderplan/HomeFirst being part of the MJHS family, is that our health system also 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 for Medicaid Beneficiaries (HMO-POS D-SNP)

Plan Overview

A health plan designed specifically for Medicare beneficiaries who also have Medicaid, that offers medical, hospital, and prescription drug coverage—all in one simple plan. Plus, extra benefits like freedom to choose any dentist or specialist in or out-of-network, an improved dental benefit, and an increased and quarterly over-the-counter (OTC)**benefit. Each member also gest a Flex card to use toward out-of-pocket costs for dental, vision, hearing and fitness, and a dedicated care manager who will be there to support and guide you by helping to coordinate your benefits, answering your questions and more.

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

Elderplan. Leading the way to great care.

Contents

Benefits at a Glance

Freedom to choose any specialist or dentist in and out-of-network	**$0**
Monthly Premium*	
Doctor Visits (Primary Care)*	
Specialist Care*	
Expanded Acupuncture	
Brain Games with BrainHQ®	
Supplemental Preventive Dental and Supplemental Comprehensive Dental	
Routine Hearing	
Routine Podiatry	
Routine Vision	
Silver&Fit® Fitness Program	
Transportation	
24/7 Access to Care with Teladoc®	
Flex Card‡	**$500** every year
Over-the-Counter (OTC) Benefits	**$660** every quarter
Traditional OTC plus now including payments toward rent/mortgage, utilities, Internet, certain grocery items, home-delivered meals. **	

*If you do not receive Medicare cost-sharing assistance under Medicaid:

- You pay $31.30 monthly for the plan premium.
- You pay 20% coinsurance for Primary Care.
- You pay 20% coinsurance for Specialist Care.

**Eligibility is determined by whether you have a chronic condition associated with SSBCI benefit (expanded OTC). Examples of SSBCI conditions include, but are not limited to, Cardiovascular Disorders, Diabetes, Arthritis, Chronic Lung Disorders and Cancer. There are other eligible conditions not listed. Standards may vary for this benefit.

‡Flex Card benefit offers $500 allowance to use in 2025 on out-of-pocket expenses 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.

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 2025 Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) Evidence of Coverage. A copy of the Evidence of Coverage is located on our website at **www.elderplan.org**.

Elderplan Contact Information

Elderplan for Medicaid Beneficiaries 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 for Medicaid Beneficiaries 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 For Medicaid Beneficiaries (HMO-POS D-SNP), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and New York State's Medicaid program and live in our service area.

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

People who qualify for Medicare and Medicaid are known as dual-eligible beneficiaries. You must be eligible for Medicaid coverage and meet the enrollment eligibility requirements for Elderplan for Medicaid Beneficiaries. The kind of Medicaid benefits you receive are determined by New York State and may vary based upon your income and resources. With the assistance of Medicaid, some dual-eligible beneficiaries do not have to pay for certain Medicare costs. As an Elderplan for Medicaid Beneficiaries member who qualifies for Medicaid coverage, additional benefits may be available to you from Medicaid.

Useful Information About Medicare

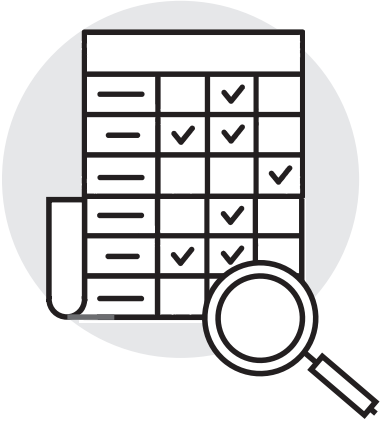
You have choices about how to get your Medicare Benefits

- 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 For Medicaid Beneficiaries (HMO-POS D-SNP)).

Tips for Comparing your Medicare Choices

This Summary of Benefits booklet gives you a summary of what Elderplan For Medicaid Beneficiaries (HMO-POS D-SNP) covers and what you pay.

- You can compare Elderplan for Medicaid Beneficiaries 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 Medicaid section includes information about services that you may receive from Medicaid. 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 for Medicaid Beneficiaries

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be: eligible for both Medicare and Medicaid, or eligible for Medicare and Medicare cost-sharing assistance under Medicaid. Additionally, you:

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

The kind of Medicaid benefits you receive are determined by New York State and may vary based upon your income and resources. With the assistance of Medicaid, some dual-eligible beneficiaries do not have to pay for certain Medicare costs. The Medicaid benefit categories and types of assistance served by our plan are listed below:

- **Full Benefit Dual Eligible (FBDE):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance and copayments). These individuals are also eligible for full Medicaid benefits.
- **Qualified Medicare Beneficiary (QMB & QMB+):** Helps pay Medicare Part A

and Part B premiums, and other cost-sharing (like deductibles, coinsurance and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled and Working Individuals (QDWI):** Helps pay Part A premiums.

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within three (3) months, then you are still eligible for membership in our plan (Chapter 4, Section 2.1 of your Evidence of Coverage booklet tells you about coverage and cost-sharing during a period of deemed continued eligibility.)

Which Doctors, Hospitals and Pharmacies can I use?

Elderplan For Medicaid Beneficiaries (HMO-POS D-SNP) 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?

Most of our members in Elderplan for Medicaid Beneficiaries get "Extra Help" with their prescription drug costs. If you receive "Extra Help," your deductible and cost share amount will depend on the level of "Extra Help" you receive. As a member of our plan, you will receive a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or "LIS Rider"), which tells you about your drug coverage. Please refer to the "LIS Rider" for information about your deductible and cost share amounts.

If you do **not** receive "Extra Help," you are responsible for your Part D drug costs.

If you have questions about Extra Help, call:

- **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**, 24 hours a day, 7 days a week;
- The Social Security Office at **1-800-772-1213** between 8 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778** (applications); or
- New York State Department of Health (Social Services) HRA Medicaid Helpline at **1-888-692-6116** between 9 a.m. and 5 p.m., Monday through Friday. TTY users should call **711**.

Section II: Summary of Benefits

The following are the health care costs for Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP). If you meet the eligibility requirements to be in this plan, Medicaid may help pay any health care expenses you may have.

Elderplan For Medicaid Beneficiaries (HMO-POS D-SNP)		
Monthly Premium (Part D Premium)	$0 or $31.30	You must continue to pay your Part B Premium (unless your Part B Premium is paid for you by Medicaid or another third party.) If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your plan premium.
Part B Deductible	$0 or $240^	If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your Part B Deductible. This plan has deductibles for Inpatient Hospital Services and Inpatient Psychiatric Services.

^These are 2024 cost-sharing amounts and may change for 2025. Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) will provide updated rates at www.elderplan.org as soon as they are released.

Elderplan For Medicaid Beneficiaries (HMO-POS D-SNP)		
Combined Maximum Out-of-Pocket	$9,350 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 your 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. If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the combined maximum out-of-pocket amount for covered Part A and Part B services.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need hospital care	Inpatient Hospital Services	A per admission deductible is applied once during the defined benefit period. In 2024^ the amounts for each benefit period are $0* or: $1,632 deductible. Days 1–60: $0 copayment per day. Days 61–90: $408 copayment per day. Days 91 and beyond: $816 copayment per lifetime reserve day. Beyond lifetime reserve days: you pay all costs.	Authorization is required.

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

^These are 2024 cost-sharing amounts and may change for 2025. Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) will provide updated rates at www.elderplan.org as soon as they are released.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need hospital care *(continued)*	Outpatient Hospital Services	0% or 20% coinsurance.*	
	Ambulatory Surgical Center (ASC)	0% or 20% coinsurance.*	

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You want to see a doctor	Primary Care Providers	0% or 20% coinsurance for each visit.*	This benefit is also available through Telehealth. Please call your current provider for details.
	Specialists	**In-Network:** 0% or 20% coinsurance for each visit.* **Out-of-Network:** 0% or 20% coinsurance for each visit.*	This benefit is also available in-network through Telehealth. Please call your current provider for details.
	Nurse Practitioners and Physician Assistants	**In-Network:** 0% or 20% coinsurance for each visit.* **Out-of-Network:** 0% or 20% coinsurance for each visit.*	Authorization only required for in-home visits.

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

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.	Preventive care services may be covered by Medicare during the benefit year.
		• Abdominal aortic aneurysm screening • Alcohol misuse screenings & counseling • Blood-based biomarker tests • Bone mass measurements • Cardiovascular disease screenings • Cardiovascular disease (behavioral therapy) • 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 • Counseling to prevent tobacco use & tobacco-caused disease	

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)*	• Depression screenings • Diabetes screenings • Hepatitis B shots • Hepatitis B Virus (HBV) infection screenings • Hepatitis C Screening Tests • HIV screenings • Lung cancer screening • Mammograms (screening) • Medical nutrition therapy services • Medicare Diabetes Prevention Program • Obesity screenings and counseling • One-time "Welcome to Medicare" preventive visit • Prostate cancer screenings (PSA) • Sexually transmitted infections screenings & counseling • Shots: - COVID-19 vaccines - Flu shots - Hepatitis B shots - Pneumococcal shots • Yearly "Wellness" Visit	

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)*	0% or 20% coinsurance.*	• Diabetes self-management training • Glaucoma Screenings
You Need Emergency Care	Emergency Care	0% or 20% coinsurance (up to $110) for each visit.*	If you are admitted to the hospital within 24 hours there is no cost share.
	Urgent Care	0% or 20% coinsurance (up to $45) for each visit.*	This benefit is also available through Telehealth. Please call your current provider for details.

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

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 • Outpatient X-rays	0% or 20% coinsurance for each service*.	

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need medical tests *(continued)*	• Therapeutic radiology services (such as radiation treatment for cancer) • Diagnostic Radiological services (such as MRI scans and CT scans)	0% or 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).

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Hearing Care	Hearing Exams	0% or 20% coinsurance for Medicare-covered hearing exams.*	
		$0 payment for one Non-Medicare-covered (Routine) Hearing Exams every 3 years.	
	Hearing Aids	Up to $1,300 for both ears combined maximum benefit limit every 3 years. $0 copayment for Fitting and Evaluation for Hearing Aid(s) every 3 years.	Authorization is required for hearing aid(s) by a Physician or Specialist.

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Dental Care	Comprehensive Dental	0% or 20% coinsurance for Medicare-Covered services.*	
	Supplemental Diagnostic and Preventive Dental Services	Supplemental Diagnostic and Preventive Dental Services is limited to selected service codes from the categories below. Services are combined in and out of network.	

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

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

Supplemental Diagnostic, Preventive & Comprehensive Dental Services

In-Network and Out-of-Network

Covered Services	Copayment	Frequency
Supplemental Diagnostic & Preventive Dental Services		
Oral Exams		
Periodic Oral Evaluation	No Charge	Once every 6 months
Limited Oral Exam	No Charge	Once per month
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
Dental X-Rays		
Complete Series X-rays	No Charge	Once every 36 months
Periapical X-ray	No Charge	Covered
Periapical X-ray, each additional film	No Charge	Covered
Occlusal X-ray	No Charge	Once every 6 months
2-D Projection X-ray	No Charge	Once every 6 months
Extra-oral posterior dental radiographic image	No Charge	Once every 6 months
Bitewing X-ray – single image	No Charge	Once every 6 months
Bitewing X-ray – two images	No Charge	Once every 6 months

Dental X-Rays		
Bitewing X-ray – three images	No Charge	Once every 6 months
Bitewing X-ray – four images	No Charge	Once every 6 months
Vertical Bitewing X-rays – seven to eight images	No Charge	Once every 6 months
Saliography	No Charge	Twice every 12 months
Temporomandibular Joint Arthrogram, including injection	No Charge	Covered
Panoramic X-ray	No Charge	Once every 36 months
Cephalometric X-ray	No Charge	Once every 36 months
2-D Photographic Images	No Charge	Twice every 6 months
Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	No Charge	Covered
Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	No Charge	Covered
Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	No Charge	Covered
Cone beam ct capture	No Charge	Covered

Dental X-Rays		
Cone beam CT capture and interpretation for TMJ series including two or more exposures	No Charge	Covered
Intraoral tomosynthesis - comprehensive series	No Charge	Once every 36 months
Intraoral tomosynthesis - bitewing image	No Charge	Once every 12 months
Intraoral tomosynthesis - periapical image	No Charge	Once every 12 months
Intraoral tomosynthesis - comprehensive series image capture	No Charge	Covered
Intraoral tomosynthesis - bitewing image capture	No Charge	Covered
Intraoral tomosynthesis - periapical image capture	No Charge	Once every 12 months
Diagnostic casts	No Charge	Once every 12 months
Accession of tissue, gross and microscopic exam, includes assessment of margins, prep and transmission of report	No Charge	Covered

Dental X-Rays		
Consultation, including preparation of slides from biopsy materials supplied by referring source	No Charge	Covered
Other oral pathology procedures, by report	No Charge	Covered
Unspecified diagnostic procedure, by report	No Charge	Covered
Cleanings		
Prophylaxis (Cleaning) – Adult	No Charge	Once every 6 months
Tobacco counseling for control of oral disease	No Charge	Covered
Unspecified preventive procedure, by report	No Charge	Covered
Other Diagnostic Services		
Unspecified diagnostic procedure	No Charge	Covered
Supplemental Comprehensive Dental Services		
Restorative Services		
Silver Filling – One Surface	No Charge	Once every 12 months
Silver Filling – Two Surfaces	No Charge	Once every 12 months
Silver Filling – Three Surfaces	No Charge	Once every 12 months

Restorative Services		
Silver Filling – Four or More Surfaces	No Charge	Once every 12 months
Tooth-colored Filling – One Surface, Front	No Charge	Once every 12 months
Tooth-colored Filling – Two Surfaces, Front	No Charge	Once every 12 months
Tooth-colored Filling – Three Surfaces, Front	No Charge	Once every 12 months
Tooth-colored Filling – Four or More Surfaces, Front	No Charge	Once every 12 months
Tooth-colored Crown – Front	No Charge	Once every 12 months
Tooth-colored Filling – One Surface, Back	No Charge	Once every 12 months
Tooth-colored Filling – Two Surfaces, Back	No Charge	Once every 12 months
Tooth-colored Filling – Three Surfaces, Back	No Charge	Once every 12 months
Tooth-colored Filling – Four or More Surfaces, Back	No Charge	Once every 12 months
Inlay – Metallic, One Surface	No Charge	Once every 60 months
Inlay – Metallic, Two Surfaces	No Charge	Once every 60 months

Restorative Services		
Inlay – Metallic, Three or More Surfaces	No Charge	Once every 60 months
Onlay – Metallic, Two Surfaces	No Charge	Once every 60 months
Inlay – Porcelain/Ceramic, Two Surfaces	No Charge	Once every 60 months
Inlay – Porcelain/Ceramic, Three or More Surfaces	No Charge	Once every 60 months
Crown – Resin-Based Composite	No Charge	Once every 60 months
Crown – 3/4 Resin-Based Composite	No Charge	Once every 60 months
Crown – Resin with High Noble Metal	No Charge	Once every 60 months
Crown – Resin with Predominantly Base Metal	No Charge	Once every 60 months
Crown – Resin with Noble Metal	No Charge	Once every 60 months
Crown – Porcelain/Ceramic Substrate	No Charge	Once every 60 months
Crown – Porcelain Fused to High Noble Metal	No Charge	Once every 60 months
Crown – Porcelain Fused to Predominantly Base Metal	No Charge	Once every 60 months

Restorative Services		
Crown – Porcelain Fused to Noble Metal	No Charge	Once every 60 months
Crown – Porcelain Fused to Titanium/Titanium Alloys	No Charge	Once every 60 months
Crown - 3/4 Cast High Noble Metal	No Charge	Once every 60 months
Crown - 3/4 Case Base Metal	No Charge	Once every 60 months
Crown - 3/4 Cast Noble Metal	No Charge	Once every 60 months
Crown – Full Cast High Noble Metal	No Charge	Once every 60 months
Crown – Full Cast Predominantly Base Metal	No Charge	Once every 60 months
Crown – Full Cast Noble Metal	No Charge	Once every 60 months
Crown - Titanium And Titanium Alloys	No Charge	Once every 60 months
Re-cement or Re-bond Inlay, Onlay or Veneer	No Charge	Covered
Re-cement or Re-bond Crown	No Charge	Covered
Prefabricated stainless steel crown-permanent	No Charge	Once every 60 months

Restorative Services		
Prefabricated Resin Crown	No Charge	Once every 24 months
Pin retention-per tooth, in addition to restoration	No Charge	Twice every 12 months
Post and Core in Addition to Crown	No Charge	Once per 60 months
Each Additional Indirectly Fabricated Post	No Charge	Once per 60 months
Prefabricated Post and Core in Addition to Crown	No Charge	Once per 60 months
Post Removal	No Charge	Once per lifetime
Crown repair necessitated by restorative material failure	No Charge	Covered
Unspecified restorative procedure, by report	No Charge	Covered
Endodontic Services		
Pulpal therapy (resorbable filling)- anterior, primary tooth, (excluding final restoration)	No Charge	Once per lifetime
Pulpal therapy (resorbable filling)- posterior, primary tooth, (excluding final restoration)	No Charge	Once per lifetime

Endodontic Services		
Root Canal Therapy, Front Tooth	No Charge	Once per lifetime
Root Canal Therapy, Bicuspid Tooth	No Charge	Once per lifetime
Root Canal Therapy, Back Tooth	No Charge	Once per lifetime
Retreatment of Root Canal Therapy, Front Tooth	No Charge	Once per lifetime
Retreatment of Root Canal Therapy, Bicuspid Tooth	No Charge	Once per lifetime
Retreatment of Root Canal Therapy, Back Tooth	No Charge	Once per lifetime
Apicoectomy/periradicular-ant	No Charge	Once per lifetime
Apicoectomy/periradicular-bicuspid (first root)	No Charge	Once per lifetime
Apicoectomy/periradicular surgery-molar (first root)	No Charge	Once per lifetime
Apicoectomy/periradicular surgery (each additional root)	No Charge	Once per lifetime
Retrograde filling - per root	No Charge	Once per lifetime
Unspecified endodontic procedure, by report	No Charge	Covered

Periodontics Services		
Gingivectomy-gingivoplasty-four or more contiguous teeth or bounded teeth spaces per quadrant	No Charge	Once per 36 months
Gingivectomy - one to three teeth per quadrant	No Charge	Once per 12 months
Gingival flap procedure - four or more teeth	No Charge	Once per 60 months
Apically positioned flap	No Charge	Covered
Clinical crown legthening - hard tissue	No Charge	Once per lifetime
Osseous surgery - per quadrant	No Charge	Once per 60 months
Osseous surgery (including flap entry and closure)- one to three contiguous teeth or bounded teeth spaces per quadrant	No Charge	Once per 60 months
Guided tissue regeneration, natural teeth - resorbable barrier, per site	No Charge	Once per lifetime
Guided tissue regeneration, natural teeth - non-resorbable barrier, per site	No Charge	Once per lifetime

Periodontics Services		
Subepithelial Connective Tissue Graft Procedures	No Charge	Once per lifetime
Soft Tissue Allograft	No Charge	Once per lifetime
Free Soft Tissue Graft Procedure- First Tooth	No Charge	Once per lifetime
Free Soft Tissue Graft Procedure- Additional Tooth	No Charge	Once per lifetime
Autogenous Connective Tissue Graft - Addl Tooth	No Charge	Once per lifetime
Non-Autogenous Connective Tissue Graft-Addl Tooth	No Charge	Once per lifetime
Perio scaling and root plan/quad	No Charge	Once per 24 months
Perio scaling and root planing, 1-3 teeth	No Charge	Once per 24 months
Periodontal maintenance	No Charge	Once per 6 months
Unspecified periodontal procedure, by report	No Charge	Covered
Prosthodontic Removable Services		
Complete denture - maxillary	No Charge	Covered
Complete denture - mandibular	No Charge	Covered

Prosthodontic Removable Services		
Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)	No Charge	Covered
Mandibular partial denture	No Charge	Covered
Maxillary part denture-cast metal	No Charge	Covered
Mandibular part denture-metal	No Charge	Covered
Upper Partial Denture - Flexible Base	No Charge	Covered
Lower Partial Denture - Flexible Base	No Charge	Covered
Adjust complete denture-maxillary	No Charge	Four per 12 months
Adjust complete denture - mandibular	No Charge	Four per 12 months
Adjust partial denture - maxillary	No Charge	Four per 12 months
Adjust partial denture - mandibular	No Charge	Four per 12 months
Repair Broken Complete Denture Base, Mandibular	No Charge	Twice per 12 months
Repair Broken Complete Denture Base, Maxillary	No Charge	Twice per 12 months

Prosthodontic Removable Services		
Replace missing or broken teeth -complete denture (each tooth)	No Charge	Once per 12 months
Repair Resin Partial Denture Base, Mandibular	No Charge	Twice per 12 months
Repair Resin Partial Denture Base, Maxillary	No Charge	Twice per 12 months
Repair Cast Partial Framework, Mandibular	No Charge	Once per 12 months
Repair Cast Partial Framework, Maxillary	No Charge	Once per 12 months
Repair or replace broken clasp	No Charge	Twice 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 complete maxillary denture	No Charge	Once per 24 months
Rebase complete mandibular denture	No Charge	Once per 24 months
Rebase maxillary partial denture	No Charge	Once per 24 months

Prosthodontic Removable Services		
Rebase mandibulary partial denture	No Charge	Once per 24 months
Rebase hybrid prosthesis	No Charge	Once per 24 months
Reline complete maxillary denture (chairside)	No Charge	Once per 24 months
Reline complete mandibular denture (chairside)	No Charge	Once per 24 months
Reline maxillary partial denture (chairside)	No Charge	Once per 24 months
Reline mandibular partial denture (chairside)	No Charge	Once per 24 months
Reline complete maxillary denture (laboratory)	No Charge	Once per 24 months
Reline complete mandibular denture (laboratory)	No Charge	Once per 24 months
Reline maxillary partial denture (laboratory)	No Charge	Once per 24 months
Reline mandibular partial denture (laboratory)	No Charge	Once per 24 months
Interim Partial Denture - Upper	No Charge	Once per 12 months
Interim Partial Denture - Lower	No Charge	Once per 12 months
Tissue Conditioning - Upper	No Charge	Once per 12 months

Maxillofacial Prosthetics		
Tissue Conditioning - Lower	No Charge	Once per 12 months
Unspecified Removable Prosthodontic Procedure	No Charge	Covered
Fluoride Gel Carrier	No Charge	Twice per 12 months
Unspecified Maxillofacial Prosthesis, By Report	No Charge	Covered
Implants Services		
Surgical Placement Implant Body: Endosteal Implant	No Charge	Once per lifetime
Surgical Placement Of Mini Implant	No Charge	Once per lifetime
Dental Implant Supported Connecting Bar	No Charge	Once per 8 years
Prefabricated Abutment - Includes Placement	No Charge	Once per 8 years
Custom Fabricated Abutment - Includes Placement	No Charge	Once per 8 years
Abutment Supported Porcelain/Ceramic Crown	No Charge	Once per 8 years
Abutment Supported Porcelain/Hi-Noble Metal Crown	No Charge	Once per 8 years

Implants Services		
Abutment Supported Porcelain/Base Metal Crown	No Charge	Once per 8 years
Abutment Supported Porcelain/Noble Metal Crown	No Charge	Once per 8 years
Abutment Supported Cast Hi-Noble Metal Crown	No Charge	Once per 8 years
Abutment Supported Cast Base Metal Crown	No Charge	Once per 8 years
Abutment Supported Cast Noble Metal Crown	No Charge	Once per 8 years
Implant Supported Porcelain/Ceramic Crown	No Charge	Once per 8 years
Implant Supported Porcelain/ Hi-Noble Metal Crown	No Charge	Once per 8 years
Implant Supported Hi-Noble Metal Crown	No Charge	Once per 8 years
Scaling And Debridement - Single Implant	No Charge	Once per 12 months
Repair Implant Supported Prosthesis	No Charge	Once per 12 months
Replacement Precision Attachment Replacement Part	No Charge	Once per 12 months
Recement/Rebond Implant/ Abutment Supported Crown	No Charge	Once per 24 months

Implants Services		
Recement/Rebond Implant/ Abutment Supported Denture	No Charge	Once per 24 months
Abutment Supported Crown-Titanium/Titanium Alloys	No Charge	Once per 8 years
Repaid Implant Abutment	No Charge	Once per 12 months
Removal of Broken Implant Retaining Screw	No Charge	Once per 12 months
Surgical Removal Of Implant Body	No Charge	Covered
Debridement Of Pariimplant Defect	No Charge	Once per 24 months
Debridement And Contouring Of Pariimplant Defect	No Charge	Once per 24 months
Bone Graft For Repair Of Pariimplant Defect	No Charge	Once per 24 months
Bone Graft At Time Of Implant Placement	No Charge	Once per lifetime
Guided Tissue Regeneration - Resorbable Barrier, Per Implant	No Charge	Covered

Implants Services		
Guided Tissue Regeneration - Non-Resorbable Barrier, Per Implant	No Charge	Covered
Implant/Abutment Supported Removable Upper Denture	No Charge	Once per 8 years
Implant/Abutment Supported Removable Lower Denture	No Charge	Once per 8 years
Implant/Abutment Supported Removable Upper Denture	No Charge	Once per 8 years
Implant/Abutment Supported Removable Full Lower Denture	No Charge	Once per 8 years
Radiographic/Surgical Implant Index	No Charge	Once per 12 months
Semi-Precision Abutment - Placement	No Charge	Once per 8 years
Semi-Precision Attachment - Placement	No Charge	Once per 8 years
Unspecified Implant Procedure, By Report	No Charge	Covered

Prosthodontics Fixed Services		
Pontic - Cast High Noble Metal	No Charge	Once per 60 months
Pontic - Cast Predominately Base Metal	No Charge	Once per 60 months
Pontic - Cast Noble Metal	No Charge	Once per 60 months
Pontic - Titanium and Titanium Alloys	No Charge	Once per 60 months
Pontic-Porcelain Fused-High Noble	No Charge	Once per 60 months
Pontic-Porcelain Fused Metal	No Charge	Once per 60 months
Pontic-Porcelain Fused-Noble Metal	No Charge	Once per 60 months
Pontic - Porcelain/Titanium And Titanium Alloys	No Charge	Once per 60 months
Pontic-Porcelain/Ceramic	No Charge	Once per 60 months
Pontic - Resin With High Noble Metal	No Charge	Once per 60 months
Pontic-Resin With Base Metal	No Charge	Once per 60 months
Pontic-Resin With Noble Metal	No Charge	Once per 60 months
Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	No Charge	Once per 60 months

Prosthodontics Fixed Services		
Crown - Resin With High Noble Metal	No Charge	Once per 60 months
Crown - Resin With Predominantly Base Metal	No Charge	Once per 60 months
Crown - Resin With Noble Metal	No Charge	Once per 60 months
Crown - Porcelain/Ceramic	No Charge	Once per 60 months
Crown-Porcelain Fused High Noble	No Charge	Once per 60 months
Crown-Porcelain Fused To Metal	No Charge	Once per 60 months
Crown-Porcelain Fused Noble Metal	No Charge	Once per 60 months
Retainer Crown-Porcelain/ Titanium And Alloys	No Charge	Once per 60 months
Retainer Crown - 3/4 Cast High Noble Metal	No Charge	Once per 60 months
Retainer Crown-3/4 Cast Predominantly Based Metal	No Charge	Once per 60 months
Retainer Crown-3/4 Cast Noble Metal	No Charge	Once per 60 months
Retainer Crown-3/4 Porcelain/Ceramic	No Charge	Once per 60 months

Prosthodontics Fixed Services		
Retainer Crown 3/4 - Titanium And Titanium Alloys	No Charge	Once per 60 months
Crown-Full Cast High Noble	No Charge	Once per 60 months
Crown - Full Cast Base Metal	No Charge	Once per 60 months
Crown - Full Cast Noble Metal	No Charge	Once per 60 months
Retainer Crown - Titanium And Titanium Alloys	No Charge	Once per 60 months
Recement Fixed Partial Denture	No Charge	Once per 24 months
Fixed Partial Denture Repair	No Charge	Once per 60 months
Oral and Maxillofacial Surgery Services		
Extraction, Coronal Remnants - Primary Tooth	No Charge	Once per lifetime
Extraction - Erupted Or Exposed Root	No Charge	Once per lifetime
Surgical Removal Erupted Tooth	No Charge	Once per lifetime
Removal Impacted Tooth-Soft	No Charge	Once per lifetime

Oral and Maxillofacial Surgery Services		
Removal Of Impacted Tooth - Partially Bony	No Charge	Once per lifetime
Remove Impact Tooth-Comp Bony	No Charge	Once per lifetime
Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	No Charge	Once per lifetime
Surgical Remove Residual Roots	No Charge	Once per lifetime
Oralantral Fistula Closure	No Charge	Once per lifetime
Primary Closure Of A Sinus Perforation	No Charge	Once per lifetime
Tooth Reimplantation And/Or Stabilization Of Accidentally Evulsed Or Displaced Tooth	No Charge	Once per lifetime
Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)	No Charge	Once per lifetime
Surgical Access Of An Unerupted Tooth	No Charge	Once per lifetime

Oral and Maxillofacial Surgery Services		
Placement Of Device To Facilitate Eruption Of Impacted Tooth	No Charge	Once per lifetime
Incisional Biopsy Of Oral Tissue-Hard (Bone/Tooth)	No Charge	Once per lifetime
Incisional Biopsy Of Oral Tissue-Soft	No Charge	Once per lifetime
Surgical Repositioning Of Teeth	No Charge	Once per lifetime
Alveoloplasty W Extract/ Quad	No Charge	Once per lifetime
Alveoloplasty W/ Extractions - 1-3 Teeth Per Quad	No Charge	Once per lifetime
Alveoloplasty - Per Quad	No Charge	Once per lifetime
Alveoloplasty Not W/ Extractions - 1-3 Teeth/ Quad	No Charge	Once per lifetime
Vestibuloplasty - Ridge Extension (Second Epitheliazation)	No Charge	Once per 60 months
Vestibuloplasty (Including Grafts)	No Charge	Once per 60 months
Excision Of Benign Lesion Of Up 1.25 Cm	No Charge	Covered

Oral and Maxillofacial Surgery Services		
Excision Of Benign Lesion Greater Than 1.25 Cm	No Charge	Covered
Excision Of Benign Lesion, Complicated	No Charge	Covered
Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	No Charge	Covered
Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	No Charge	Covered
Removal Of Benign Nonodontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	No Charge	Covered
Removal Of Benign Nonodontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	No Charge	Covered
Removal Of Lateral Exostosis (Maxilla Or Mandible)	No Charge	Once per lifetime
Removal Of Torus Mandibularis	No Charge	Covered

Oral and Maxillofacial Surgery Services		
Surgical Reduction Of Osseous Tuberosity	No Charge	Once per lifetime
Incision And Drainage Of Abscess - Intraoral Soft Tissue	No Charge	Covered
Incicion And Drainage Of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage Of Multiple Fascial Spaces)	No Charge	Covered
Incision And Drainage Of Abscess - Extraoral Soft Tissue	No Charge	Covered
Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated (Includes Drainage Of Multiple Fascial Spaces)	No Charge	Covered
Removal Of Foreign Body	No Charge	Covered
Removal Of Foreign Bodies	No Charge	Covered
Partial Ostectomy/ Sequestrectomy	No Charge	Covered
Maxillary Sinusotomy For Removal Of Tooth Fragment	No Charge	Covered

Oral and Maxillofacial Surgery Services		
Suture Of Recent Small Wounds	No Charge	Covered
Sinus Augmentation With Bone Or Bone Substitutes	No Charge	Covered
Sinus Augmentation Via A Vertical Approach	No Charge	Covered
Bone Replacement Graft For Ridge Preservation	No Charge	Covered
Buccal/Labial Frenectomy (Frenulectomy)	No Charge	Three per lifetime
Lingual Frenectomy (Frenulectomy)	No Charge	Three per lifetime
Excision Of Hyperplastic Tissue - Per Arch	No Charge	Twice per lifetime
Excision Of Pericoronal Gingiva	No Charge	Once per 24 months
Surgical Reduction Of Fibrous Tuberosity	No Charge	Twice per lifetime
Appliance Removal (Not By Dentist Who Placed Appliance), Includes Removal Of Archbar	No Charge	Covered
Unspecified Oral Surgery Procedure, By Report	No Charge	Covered

Adjunctive General Services		
Palliative (Emergency) Treat	No Charge	Twice per 12 months
Fixed Partial Denture Sectioning	No Charge	Covered
Deep Sedation/General Anesthesia - First 15 Minutes	No Charge	Covered
Deep Sedation/General Anesthesia - Each 15 Minutes	No Charge	Covered
Intravenous Moderate (Conscious) Sedation/ Anesthesia - First 15 Minutes	No Charge	Covered
Intravenous Moderate (Conscious) Sedation - 15 Min	No Charge	Covered
Consultation - Diagnostic Service Provided By Dentist Or Physician Other Than Requesting Dentist Or Physician	No Charge	Once per 6 months
House/Extended Care Facility Call	No Charge	Covered
Hospital Or Ambulatory Surgical Center Call	No Charge	Covered

Adjunctive General Services		
Office Visit For Observation (During Regularly Scheduled Hours)-No Other Services Performed	No Charge	Covered
Office Visit - After Regularly Scheduled Hours	No Charge	Covered
Therapeutic Parenteral Drug, Single Administration	No Charge	Covered
Therapeutic Parenteral Drugs, Two Or More Administrations, Different Medications	No Charge	Covered
Occlusal Guard - Hard Appliance, Full Arch	No Charge	Once per 12 months
Occlusal Guard - Soft Appliance, Full Arch	No Charge	Once per 12 months
Occlusal Guard - Hard Appliance, Partial Arch	No Charge	Once per 12 months
Certified Translation Or Sign-Language Services - Per Visit	No Charge	Covered
Teledentistry - Synchronous; Real-Time Encounter	No Charge	Covered

Adjunctive General Services		
Teledentistry-Asynchronous; Information Stored And Forwarded To Dentist For Subsequent Review	No Charge	Covered
"Dental Case Management - Patients With Special Health Care Needs"	No Charge	Once every 6 months
Unspecified Adjunctive Procedure, By Report	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	0% or 20% coinsurance for Medicare-covered eye exams.*	
		$0 Copayment for Non-Medicare-covered. (Routine eye exam for eyewear.)	You may receive one Non-Medicare-covered (Routine) 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 $350 annual maximum every year.	Includes contact lenses and eyewear.

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Mental Health Care	Inpatient Mental Health	A per admission deductible is applied once during the defined benefit period. In 2024^ the amounts for each benefit period are $0* or: $1,632 deductible. Days 1–60: $0 copayment per day. Days 61–90: $408 copayment per day. Days 91 and beyond: $816 copayment per lifetime reserve day. Beyond lifetime reserve days: you pay all costs.	Authorization is required.

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

^These are 2024 cost-sharing amounts and may change for 2025. Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) will provide updated rates at www.elderplan.org as soon as they are released.

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	Mental Health: **In-Network:** 0% or 20%* coinsurance for each Individual or Group in-office or telehealth session. **Out-of-Network:** 0% or 20%* coinsurance for each Individual or Group session.	Please call your current provider for telehealth services details.

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

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: **In-Network:** 0% or 20%* coinsurance for each Individual or Group in-office or telehealth session. **Out-of-Network:** 0% or 20%* coinsurance for each Individual or Group session.	Please call your current provider for telehealth services details.

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Rehabilitative or Skilled Nursing Care	Skilled Nursing Facility	In 2024^* the amounts for each benefit period: Days 1–20: $0 per day. Days 21–100: $204 copayment per day. Days 101 and beyond: you pay all costs.	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:** 0% or 20% coinsurance for each visit.* **Out-of-Network:** 0% or 20% coinsurance for each visit.*	Authorization is required.

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.
^These are 2024 cost-sharing amounts and may change for 2025. Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) will provide updated rates at www.elderplan.org as soon as they are released.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need help getting to health services	Ambulance	0% or 20% coinsurance for each one-way trip.*	Authorization is only required for non-emergency services.
	Transportation	$0 copayment. You may take up to 24 one-way trips for medical related purposes annually.	You may take a taxi, bus, subway, van or rideshare.
You need drugs to treat your illness or condition	Medicare Part B Drugs	0% or 20% coinsurance for each Medicare Part B prescription drugs.* Up to $35 for Medicare Part B Insulin Drugs.	Authorization may be required for certain drugs.

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Medicare Part D	
Part D Premium	$0 or $31.30 per month.
Part D Deductible	Most Elderplan for Medicaid Beneficiaries members get "Extra Help" with their prescription drug costs. For 2025, the Part D deductible is $590. If you receive "Extra Help," your deductible amount depends on the level of "Extra Help" you receive– you will pay $0* for Part D deductible. Members pay the full cost of their drugs until their deductible is met, then the cost-shares are applied in the initial coverage stage.
Initial Coverage Stage: One-Month Supply (30-Days) and Extended Supply (up to 90-Days) *^†Ω	
For **Generic Drugs** (including brand drugs treated as generic):	Depending on your Extra Help you pay: $0 copay or $1.60 copay or $4.90 copay or 25% of the cost

Medicare Part D	
For **All Other Drugs:**	Depending on your Extra Help you pay: $0 copay or $4.80 copay or $12.15 copay or 25% of the cost

*One-month supply for Standard retail (in-network), Long-term care (31-day), and Out-of-network cost-share. Extended supply for Standard retail (in-network) and Mail-order cost-sharing.

^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.

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 $2,000, you will move to the next stage (the Catastrophic stage).

Catastrophic Coverage Stage	
Once your "out-of-pocket costs" reach a total of $2,000, 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 Services			
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)	$0 copayment for Continuous Glucose Monitors and supplies are available at participating pharmacies. 0% or 20% coinsurance for Medicare-covered Durable Medical Equipment (DME).*	Continuous Glucose Monitors are limited to specific manufacturers: Freestyle Libre. Authorization is required. Authorization is required for certain items.

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Other Covered Services			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Medical Equipment and Supplies (continued)	Medical Supplies	0% or 20% coinsurance for Medical Supplies.*	Authorization is required.
	Prosthetics (artificial limbs or braces)	0% or 20% coinsurance for Prosthetic Devices.*	Authorization is required.
You need Rehabilitation Services	Physical Therapy, Occupational Therapy, Speech Language Therapy.	**In-Network** 0% or 20% coinsurance for each visit.* **Out-of-Network** 0% or 20% coinsurance for each visit.*	Authorization is required.
	Cardiac Rehabilitation	0% or 20% coinsurance for each visit.*	Authorization is required.
	Pulmonary Rehabilitation	0% or 20% coinsurance for each visit.*	Authorization is required.

*If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

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 2025 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 2025 or if you disenroll from the plan.

More benefits with your plan	
OTC	You may purchase up to $660 every quarter (3 months) of eligible OTC items on an OTC card provided by Elderplan.
OTC + Grocery + Meals + Utility Payments + Rental/Mortgage Assistance	For eligible members (with certain chronic conditions) the Special Supplemental Benefits for the Chronically Ill combines with the OTC benefit to include payments toward rent/mortgage, utilities, Internet, certain grocery items, and home delivered meals as part of the OTC allowance.
Supplemental Podiatry Services	**In-Network:** $0 copayment per visit. You may receive up to 12 Routine Foot Care visits per year. **Out-of-Network:** $0 copayment per visit. You may receive up to 12 Routine Foot Care visits per year.

More benefits with your plan

Silver&Fit® Fitness Program	The Silver&Fit® Healthy Aging and Exercise program provides Elderplan members with access to a fitness center membership at a participating location in the network and the option to choose a Home Fitness Kit including wearable fitness tracker or a strength kits. Also available, on-demand workout classes and one-on-one Well-Being Coaching sessions by phone, video, or chat with a trained coach. The Silver&Fit toll-free number is 1-877-427-4788 (TTY 711) Monday through Friday, 8 am to 9 pm
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 / Emergency Transportation / Urgent Coverage	$0 cost-sharing for Worldwide Emergency Coverage / Emergency Transportation / Urgent Coverage. The maximum benefit coverage amount is $50,000.

Section III: Summary of Medicaid Benefits Not Covered by Elderplan

There may be some services that you may be eligible for from Medicaid that are not covered by Elderplan for Medicaid Beneficiaries. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card.

If you have questions about the assistance you get from Medicaid, please use the information below to contact your appropriate New York State Department of Health (Social Services) office. Please reference the Medicaid contact table.

The following services are not covered by Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) but are available through Medicaid:

Medicaid Benefits
Medicaid Services Not Covered By Elderplan
Home Delivered or Congregate Meals Social Day Care Social and Environmental Supports
Nursing Home Care (Residential Health Care Facility)

Medicaid Benefits

Medicaid Services Not Covered By Elderplan

Home Care

a. Nursing

b. Home Health Aide

c. Physical Therapy (PT)

d. Occupational Therapy (OT)

e. Speech Pathology (SP)

f. Medical Social Services

Adult Day Health Care

Personal Care

DME – including Medical/Surgical Supplies, Enteral and Parenteral Formula, and Hearing Aid Batteries, Prosthetics, Orthotics, and Orthopedic Footwear. Enteral Formula limited to nasogastric, jejunostomy, or gastrostomy tube feeding; or treatment of an inborn error of metabolism.

Personal Emergency Response System

Non-emergent Transportation

Podiatry

Dentistry

Optometry/Eyeglasses

Medicaid Benefits

Medicaid Services Not Covered By Elderplan

Outpatient Rehabilitation services – physical therapy (PT), occupational therapy (OT), and speech therapy (ST) – that are ordered by a doctor or other licensed professional are covered as medically necessary (without limits to the number of visits).

Audiology/Hearing Aids

Respiratory Therapy

Nutrition

Private Duty Nursing

Consumer Directed Personal Assistance Services

Medicaid Fee-For-Service

Inpatient Hospital Services

Outpatient Hospital Services

Physician Services including services provided in an office setting, a clinic, a facility, or in the home.

Laboratory Services

Radiology and Radioisotope Services

Emergency Transportation

Rural Health Clinic Services

Chronic Renal Dialysis

Medicaid Benefits

Medicaid Fee-For-Service
Mental Health Services
Alcohol and Substance Abuse Services
OPWDD Services
Family Planning Services
Prescription and Non-prescription Drugs, Compounded Prescriptions
All other services listed in Title XIX State Plan

Other services may be available to you which can be accessed through Medicaid Fee-for-Service.

Contact Information for New York State Medicaid Program

Method	New York State Department of Health (Social Services) – Contact Information
CALL	HRA Medicaid Helpline: 1-888-692-6116 Nassau County: 516-227-8000 Available 9 a.m. to 4 p.m., Monday through Friday New York City: 718-557-1399 Available 9 a.m. to 5 p.m., Monday through Friday Westchester County: 914-995-3333 Available 8:30 a.m. to 5 p.m., Monday through Friday
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Method	New York State Department of Health (Social Services) – Contact Information
WRITE	New York City Human Resources Administration Medical Assistance Program Correspondence Unit 785 Atlantic Avenue 1st Floor Brooklyn, NY 11238 Nassau County Department of Social Services 60 Charles Lindbergh Boulevard Uniondale, NY 11553 Westchester County Department of Social Services 85 Court Street White Plains, NY 10601
WEBSITE	**https://www.health.ny.gov/health_care/medicaid/ldss.htm**

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) にお電話くださぃ。日本語を話す人 者 が支援ぃたします。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, 2026**.
- ☐ 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.
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.
- ☐ 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.