

# **Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) Annual Notice of Change for 2026 1**

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## **Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) offered by Elderplan, Inc.**

### **Annual Notice of Change for 2026**

You're enrolled as a member of Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP).
- To change to a **different plan**, visit [www.medicare.gov](http://www.medicare.gov) or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at [www.elderplan.org](http://www.elderplan.org) or call Member Services at 1-800-353-3765 (TTY users call 711) to get a copy by mail.

### **More Resources**

- This material is available for free in Spanish and Chinese.
- Call Member Services at 1-800-353-3765 (TTY users call 711) for more information. Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.

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- This information is 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.

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

- 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.
- Elderplan has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) through 2026 based on a review of Elderplan's Model of Care.
- When this material says "we," "us," or "our," it means Elderplan Inc. When it says "plan" or "our plan," it means Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP).
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP).** Starting January 1, 2026, you'll get your medical and drug coverage through Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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**Summary of Important Costs for 2026**

|   | <b>2025 (this year)</b>   | <b>2026 (next year)</b>   |
|---|---|---|
| <p><b>Monthly plan premium*</b></p> <p>* Your premium can be higher or lower than this amount. Go to Section 1.1 for details.</p> | <p>\$0 or \$31.30 for your Part D Premium.</p>  | <p>\$0 or \$22.70 for your Part D Premium.</p>  |
| <p><b>Part B Deductible</b></p>   | <p>The Part B Deductible is \$257.</p> <p>If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0.</p> | <p>The Part B Deductible is \$257.</p> <p>If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0.</p> |

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|  | <b>2025 (this year)</b>  | <b>2026 (next year)</b>   |
|--|--|---|
| <p><b>Part B Deductible<br/>(continued)</b></p>  |  | <p>These are 2025 cost-sharing amounts and may change for 2026. Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) will provide updated rates at <a href="http://www.elderplan.org">www.elderplan.org</a> as soon as they are released.</p> |
| <p><b>Maximum out-of-pocket amount</b><br/>This is the <u>most</u> you'll pay out of pocket for your In-Network and out-of-network combined covered Part A and Part B services. (Go to Section 1.2 for details.)</p> | <p><b>In-Network and Out-of-Network Combined</b><br/>\$9,350<br/>If you are eligible for Medicare cost-sharing help under Medicaid, you are not responsible for paying any out-of-pocket costs</p> | <p><b>In-Network and Out-of-Network Combined</b><br/>\$9,250<br/>If you are eligible for Medicare cost-sharing help under Medicaid, you are not responsible for paying any out-of-pocket costs</p>  |

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|   | <b>2025 (this year)</b>   | <b>2026 (next year)</b>   |
|---|---|---|
| <b>Maximum out-of-pocket amount (continued)</b> | toward the maximum out-of-pocket amount for covered Part A and Part B services.   | toward the maximum out-of-pocket amount for covered Part A and Part B services.   |
| <b>Primary care office visits</b>               | <p><b>In-Network:</b><br/>You pay 0% or 20% coinsurance per visit.</p> <p>If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.</p> | <p><b>In-Network:</b><br/>You pay 0% or 20% coinsurance per visit.</p> <p>If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.</p> <p>There is no change for 2026.</p> |

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|   | <b>2025 (this year)</b>  | <b>2026 (next year)</b>  |
|---|--|--|
| <p><b>Specialist office visits</b></p>  | <p><b>In-Network and Out-of-Network:</b><br/>You pay 0% or 20% coinsurance per visit.<br/><br/>If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.</p>                 | <p><b>In-Network and Out-of-Network:</b><br/>You pay 0% or 20% coinsurance per visit.<br/><br/>If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.<br/><br/>There is no change for 2026.</p> |
| <p><b>Inpatient hospital stays</b><br/>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to</p> | <p><b>In-Network:</b><br/>In 2025 the amounts for each benefit period are \$0* OR: \$ 1,676 deductible.<br/><br/>Days 1-60:<br/>\$0 copayment per day.<br/><br/>Days 61-90:<br/>\$419 copayment per day.</p> | <p><b>In-Network:</b><br/>In 2025 the amounts for each benefit period are \$0* OR: \$ 1,676 deductible.<br/><br/>Days 1-60:<br/>\$0 copayment per day.<br/><br/>Days 61-90:<br/>\$419 copayment per day.</p>                       |

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|   | <b>2025 (this year)</b>   | <b>2026 (next year)</b>   |
|---|---|---|
| <p><b>Inpatient hospital stays (continued)</b><br/>the hospital with a doctor’s order. The day before you’re discharged is your last inpatient day.</p> | <p>Days 91 and beyond: \$838 copayment per lifetime reserve day.<br/>Beyond lifetime reserve days: you pay all costs.<br/>Authorization is required.<br/>If you get authorized inpatient care at an out-of-network hospital after your Emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.<br/>If you are eligible for Medicare cost-sharing help</p> | <p>Days 91 and beyond: \$838 copayment per lifetime reserve day.<br/>Beyond lifetime reserve days: you pay all costs.<br/>Authorization is required.<br/>If you get authorized inpatient care at an out-of-network hospital after your Emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.<br/>If you are eligible for Medicare cost-sharing help</p> |

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|  | <b>2025 (this year)</b>   | <b>2026 (next year)</b>  |
|--|---|--|
| <b>Inpatient hospital stays (continued)</b>                                | under Medicaid, you pay \$0.  | under Medicaid, you pay \$0.<br><br>These are 2025 cost-sharing amounts and may change for 2026. Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) will provide updated rates at <a href="http://www.elderplan.org">www.elderplan.org</a> as soon as they are released. |
| <b>Part D drug coverage deductible</b><br>(Go to Section 1.5 for details.) | The Part D Deductible is \$590, except for covered insulin products and most adult Part D vaccines. | The Part D Deductible is \$615, except for covered insulin products and most adult Part D vaccines.  |

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|  | 2025 (this year)  | 2026 (next year)  |
|--|---|---|
| <p><b>Part D drug coverage</b><br/>(Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)</p> | <p>During the Initial Coverage Stage:<br/>Standard retail cost sharing (in-network) (up to a 90-day supply) * †<br/><b>Ω</b><br/>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing for:<br/><b>Tier 1:</b><br/>Depending on your “Extra Help”<br/>You Pay:<br/><b>For generic drugs</b> (including brand drugs treated as generic):<br/>\$0 copay or<br/>\$1.60 copay or<br/>\$4.90 copay or</p> | <p>During the Initial Coverage Stage:<br/>Standard retail cost sharing (in-network) (up to a 90-day supply) * †<br/><b>Ω</b><br/>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing for:<br/><b>Tier 1:</b><br/>Depending on your “Extra Help”<br/>You Pay:<br/><b>For generic drugs</b> (including brand drugs treated as generic):<br/>\$0 copay or<br/>\$1.60 copay or<br/>\$5.10 copay or</p> |

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|   | 2025 (this year)   | 2026 (next year)   |
|---|--|--|
| <b>Part D drug coverage (continued)</b> | <p>25% of the total cost.</p> <p><b>For all other drugs:</b></p> <p>\$0 copay or<br/>\$4.80 copay or<br/>\$12.15 copay or<br/>25% of the cost.</p> <p>*60-Day supply is also available for Standard Retail.</p> <p><b>Mail-order cost sharing (up to 90-day supply)†Ω</b><br/>during the Initial Coverage Stage</p> <p>For:</p> <p>Tier 1: Depending on your level of “Extra Help” You Pay:</p> <p><b>For generic drugs (including brand</b></p> | <p>25% of the total cost.</p> <p><b>For all other drugs:</b></p> <p>\$0 copay or<br/>\$4.90 copay or<br/>\$12.65 copay or<br/>25% of the cost.</p> <p>*60-Day supply is also available for Standard Retail.</p> <p><b>Mail-order cost sharing (up to 90-day supply)†Ω</b><br/>during the Initial Coverage Stage</p> <p>For:</p> <p>Tier 1: Depending on your level of “Extra Help” You Pay:</p> <p><b>For generic drugs (including brand</b></p> |

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|   | <b>2025 (this year)</b>   | <b>2026 (next year)</b>   |
|---|---|---|
| <b>Part D drug coverage (continued)</b> | <p>drugs treated as generic):<br/>\$0 copay or<br/>\$1.60 copay or<br/>\$4.90 copay or<br/>25% of the cost.</p> <p><b>For all other drugs:</b><br/>\$0 copay or<br/>\$4.80 copay or<br/>\$12.15 copay or<br/>25% of the cost.</p> <p>†NDS – Non-Extended Days Supply. Certain specialty drugs will be limited up to a 30-day supply per fill.</p> <p>Ω – You will not pay more than \$35 for a one-month supply of each</p> | <p>drugs treated as generic):<br/>\$0 copay or<br/>\$1.60 copay or<br/>\$5.10 copay or<br/>25% of the cost.</p> <p><b>For all other drugs:</b><br/>\$0 copay or<br/>\$4.90 copay or<br/>\$12.65 copay or<br/>25% of the cost.</p> <p>†NDS – Non-Extended Days Supply. Certain specialty drugs will be limited up to a 30-day supply per fill.</p> <p>Ω – You will not pay more than \$35 for a one-month supply of each</p> |

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|   | <b>2025 (this year)</b>  | <b>2026 (next year)</b>  |
|---|--|--|
| <b>Part D drug coverage (continued)</b> | <p>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.</p> <p>Catastrophic Coverage Stage:</p> <p>During this payment stage, you pay nothing for your covered Part D drugs.</p> | <p>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.</p> <p>Catastrophic Coverage Stage:</p> <p>During this payment stage, you pay nothing for your covered Part D drugs.</p> |

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## SECTION 1 Changes to Benefits & Costs for Next Year

### Section 1.1 Changes to the Monthly Plan Premium

|   | 2025 (this year)   | 2026 (next year)   |
|---|--|--|
| <b>Monthly plan premium</b><br>(You must also continue to pay your Medicare Part B premium unless it's paid for you by Medicaid.) | \$0 or \$31.30 for your Part D Premium.<br><br>You must continue to pay your Part B Premium (unless your Part B Premium is paid for you by Medicaid or another third party). | \$0 or \$22.70 for your Part D Premium.<br><br>You must continue to pay your Part B Premium (unless your Part B Premium is paid for you by Medicaid or another third party). |

### Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

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|   | <b>2025 (this year)</b>  | <b>2026 (next year)</b>  |
|---|--|--|
| <p><b>Maximum out-of-pocket amount</b></p> <p>Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum.</p> <p>If you are eligible for Medicaid help with Part A and Part B copayments and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for</p> | <p><b>In-Network and Out-of-Network Combined</b></p> <p>\$9,350</p> <p>Once you have paid \$9,350 out-of-pocket for In-Network and out-of-network combined covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.</p> | <p><b>In-Network and Out-of-Network Combined</b></p> <p>\$9,250</p> <p>Once you've paid \$9,250 out of pocket for In-Network and out-of-network combined covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year.</p> |

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|   | 2025 (this year) | 2026 (next year) |
|---|------------------|------------------|
| <b>Maximum out-of-pocket amount (continued)</b><br>covered Part A and Part B services.<br>Your costs for covered medical services (such as copayments and deductibles) <b>count</b> toward your maximum out-of-pocket amount. |                  |                  |

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## Section 1.3 Changes to the Provider Network

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Our network of providers has changed for next year. Review the 2026 *Provider and Pharmacy Directory* [www.elderplan.org](http://www.elderplan.org) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider and Pharmacy Directory*:

- Visit our website at [www.elderplan.org](http://www.elderplan.org).
- Call Member Services at 1-800-353-3765 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

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We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-800-353-3765 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

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### **Section 1.4 Changes to the Pharmacy Network**

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Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Our network of pharmacies has changed for next year. Review the 2026 *Provider and Pharmacy Directory* [www.elderplan.org](http://www.elderplan.org) to see which pharmacies are in our network. Here's how to get an updated *Provider and Pharmacy Directory*:

- Visit our website at [www.elderplan.org](http://www.elderplan.org) .
- Call Member Services at 1-800-353-3765 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Provider and Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-800-353-3765 (TTY users call 711) for help.

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## Section 1.5 Changes to Benefits & Costs for Medical Services

The Annual Notice of Change tells you about changes to your Medicare benefits and costs.

|   | 2025 (this year)  | 2026 (next year)  |
|---|---|---|
| <b>Dental services - Supplemental Diagnostic and Preventive Dental Services</b> | <p><b>Supplemental Diagnostic and Preventive Services</b></p> <p><b>In-Network and Out-Of-Network Combined</b></p> <p>Coverage of Supplemental Diagnostic and Preventive Dental Services is limited to selected service codes from the categories below.</p> <p>You pay \$0 copayment for the following supplemental Diagnostic and</p> | <p><b>Supplemental Diagnostic and Preventive Services</b></p> <p><b>In-Network and Out-Of-Network Combined</b></p> <p>Coverage of Supplemental Diagnostic and Preventive Dental Services is limited to selected service codes from the categories below.</p> <p>You pay \$0 copayment for the following supplemental Diagnostic and</p> |

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|   | 2025 (this year)  | 2026 (next year)  |
|---|---|---|
| <b>Dental services -<br/>Supplemental<br/>Diagnostic and<br/>Preventive Dental<br/>Services<br/>(continued)</b> | preventative<br>Dental services:<br><u>Oral Exams</u><br><u>Services:</u> Select<br>codes include but<br>not limited to <ul style="list-style-type: none"> <li>Limited Oral Exams:<br/>1 every month</li> <li>Oral Exams:<br/>1 every<br/>6 months</li> </ul> | preventative<br>Dental services:<br><u>Oral Exams</u><br><u>Services:</u> Select<br>codes include but<br>not limited to <ul style="list-style-type: none"> <li>Limited Oral Exams:<br/>1 every month</li> <li>Oral Exams:<br/>1 every<br/>6 months or<br/>select codes<br/>covered<br/>1 every<br/>12 months</li> </ul> |
|   | <u>Dental X-Rays</u><br><u>Services:</u> Select<br>codes include but<br>not limited to <ul style="list-style-type: none"> <li>Dental X Rays:<br/>1 every<br/>6 months and<br/>1 every<br/>12 month</li> </ul>   | <u>Dental X-Rays</u><br><u>Services:</u> Select<br>codes include but<br>not limited to <ul style="list-style-type: none"> <li>Dental X Rays:<br/>1 every<br/>6 months and<br/>1 every<br/>12 month</li> </ul>   |

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|  | <b>2025 (this year)</b>   | <b>2026 (next year)</b>   |
|--|---|---|
| <p><b>Dental services - Supplemental Diagnostic and Preventive Dental Services (continued)</b></p> | <ul style="list-style-type: none"> <li>• Dental X Rays: 1 every 36 months</li> <li>• Panoramic &amp; Cephalometric Film: 1 every 36 months</li> <li>• Oral/Facial Photographic images: 2 every 6 months</li> <li>• Dental X-Rays: 2 every 12 months</li> <li>• Dental X Rays: Select codes are covered with no frequency limitation.</li> </ul> | <ul style="list-style-type: none"> <li>• Dental X Rays: 1 every 36 months</li> <li>• Panoramic &amp; Cephalometric Film: 1 every 36 months</li> <li>• Oral/Facial Photographic images: 2 every 6 months</li> <li>• Dental X-Rays: 2 every 12 months</li> <li>• Dental X Rays: Select codes are covered with no frequency limitation.</li> </ul> |

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|   | <b>2025 (this year)</b>   | <b>2026 (next year)</b>   |
|---|---|---|
| <b>Dental services -<br/>Supplemental<br/>Diagnostic and<br/>Preventive Dental<br/>Services<br/>(continued)</b> | <u>Preventive<br/>(Cleanings):</u>  | <u>Preventive<br/>(Cleanings):</u>  |
|   | <ul style="list-style-type: none"> <li>• <u>Cleanings<br/>(Prophylaxis):<br/>1 every<br/>6 months</u></li> </ul>                  | <ul style="list-style-type: none"> <li>• <u>Cleanings<br/>(Prophylaxis):<br/>1 every<br/>6 months</u></li> </ul>                  |
|   | <u>Other Diagnostic<br/>Dental Services:</u>  | <u>Other Diagnostic<br/>Dental Services:</u>  |
|   | <ul style="list-style-type: none"> <li>• <u>Select codes<br/>are covered<br/>with no<br/>frequency<br/>limitation.</u></li> </ul> | <ul style="list-style-type: none"> <li>• <u>Select codes<br/>are covered<br/>with no<br/>frequency<br/>limitation.</u></li> </ul> |
|   | <u>For more<br/>information<br/>about which<br/>services are<br/>covered please<br/>contact Member<br/>Services.</u>              | <u>For more<br/>information<br/>about which<br/>services are<br/>covered please<br/>contact Member<br/>Services.</u>              |

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|  | <b>2025 (this year)</b>  | <b>2026 (next year)</b>  |
|--|--|--|
| <b>Dental services – Comprehensive Dental Services</b> | <p><b>Supplemental Comprehensive Dental Services:</b></p> <p><b>In-Network and Out-Of-Network Combined</b></p> <p>Coverage of Supplemental Comprehensive Dental Services is limited to selected service codes from the categories below. Benefit frequency may be limited per ADA guidelines to 1 service per tooth/per arch/per quadrant.</p> <p><u>Restorative Services:</u></p> | <p><b>Supplemental Comprehensive Dental Services:</b></p> <p><b>In-Network and Out-Of-Network Combined</b></p> <p>Coverage of Supplemental Comprehensive Dental Services is limited to selected service codes from the categories below. Benefit frequency may be limited per ADA guidelines to 1 service per tooth/per arch/per quadrant.</p> <p><u>Restorative Services:</u></p> |

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|  | <b>2025 (this year)</b>   | <b>2026 (next year)</b>   |
|--|---|---|
| <b>Dental services –<br/>Comprehensive<br/>Dental Services<br/>(continued)</b> | <p>Select codes</p> <ul style="list-style-type: none"> <li>• \$0 copay / 1 every 12 months</li> <li>• \$0 copay / 1 every 24 months</li> <li>• \$0 copay / 1 every 60 months</li> <li>• \$0 copay / 2 every 12 months</li> <li>• \$0 copay / 1 per lifetime</li> <li>• Select codes are covered at \$0 copayment with no frequency limitation.</li> </ul> | <p>Select codes</p> <ul style="list-style-type: none"> <li>• \$0 copay / 1 every 12 months</li> <li>• \$0 copay / 1 every 24 months</li> <li>• \$0 copay / 1 every 60 months</li> <li>• \$0 copay / 2 every 12 months</li> <li>• \$0 copay / 1 per lifetime</li> <li>• Select codes are covered at \$0 copayment with no frequency limitation.</li> </ul> |

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|  | 2025 (this year)   | 2026 (next year)   |
|--|--|--|
| <b>Dental services –<br/>Comprehensive<br/>Dental Services<br/>(continued)</b> | <u>Endodontic<br/>Services:</u>  | <u>Endodontic<br/>Services:</u>  |
|  | Select codes   | Select codes   |
|  | <ul style="list-style-type: none"> <li>• \$0 copay / 1 per lifetime.</li> <li>• Select codes are covered at \$0 copayment with no frequency limitation.</li> </ul> | <ul style="list-style-type: none"> <li>• \$0 copay / 1 per lifetime.</li> <li>• Select codes are covered at \$0 copayment with no frequency limitation.</li> </ul> |
|  | <u>Periodontics<br/>Services:</u>  | <u>Periodontics<br/>Services:</u>  |
| Select codes   | Select codes   |  |
|  | <ul style="list-style-type: none"> <li>• \$0 copay / 1 every 6 months</li> <li>• \$0 copay / 1 every 12 months</li> </ul>  | <ul style="list-style-type: none"> <li>• \$0 copay / 1 every 6 months</li> <li>• \$0 copay / 1 every 12 months</li> </ul>  |

# Elderplan For Medicaid Beneficiaries (HMO-POS D-SNP) Annual Notice of Change for 2026 26

|  | 2025 (this year)   | 2026 (next year)   |
|--|--|--|
| <b>Dental services –<br/>Comprehensive<br/>Dental Services<br/>(continued)</b> | • \$0 copay /<br>1 every<br>24 months  | • \$0 copay /<br>1 every<br>24 months  |
|  | • \$0 copay /<br>1 every<br>36 months  | • \$0 copay /<br>1 every<br>36 months  |
|  | • \$0 copay /<br>1 every<br>60 months  | • \$0 copay /<br>1 every<br>60 months  |
|  | • \$0 copay /<br>1 per lifetime  | • \$0 copay /<br>1 per lifetime  |
|  | • Select codes<br>are covered at<br>\$0 copayment<br>with no<br>frequency<br>limitation. | • Select codes<br>are covered at<br>\$0 copayment<br>with no<br>frequency<br>limitation. |
|  | <u>Prosthodontics,<br/>removable:</u><br>Select codes                                    | <u>Prosthodontics,<br/>removable:</u><br>Select codes                                    |
| • \$0 copay /<br>1 every<br>12 months  | • \$0 copay /<br>1 every<br>12 months  |  |

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|  | 2025 (this year)  | 2026 (next year)  |
|--|---|---|
| <b>Dental services –<br/>Comprehensive<br/>Dental Services<br/>(continued)</b> | <ul style="list-style-type: none"> <li>• \$0 copay /<br/>2 every<br/>12 months</li> </ul>   | <ul style="list-style-type: none"> <li>• \$0 copay /<br/>2 every<br/>12 months</li> </ul>   |
|  | <ul style="list-style-type: none"> <li>• \$0 copay /<br/>4 every<br/>12 months</li> </ul>   | <ul style="list-style-type: none"> <li>• \$0 copay /<br/>4 every<br/>12 months</li> </ul>   |
|  | <ul style="list-style-type: none"> <li>• \$0 copay /<br/>1 every<br/>24 months</li> </ul>   | <ul style="list-style-type: none"> <li>• \$0 copay /<br/>1 every<br/>24 months</li> </ul>   |
|  | <ul style="list-style-type: none"> <li>• Select codes<br/>are covered at<br/>\$0 copayment<br/>with no<br/>frequency<br/>limitation.</li> </ul> | <ul style="list-style-type: none"> <li>• Select codes<br/>are covered at<br/>\$0 copayment<br/>with no<br/>frequency<br/>limitation.</li> </ul> |
|  | <u>Maxillofacial<br/>Prosthetics<br/>services:</u><br>Select codes  | <u>Maxillofacial<br/>Prosthetics<br/>services:</u><br>Select codes  |
|  | <ul style="list-style-type: none"> <li>• \$0 copay /<br/>2 every<br/>12 months</li> </ul>   | <ul style="list-style-type: none"> <li>• \$0 copay /<br/>1 every<br/>6 months</li> </ul>  |

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|  | 2025 (this year)  | 2026 (next year)  |
|--|---|---|
| <b>Dental services –<br/>Comprehensive<br/>Dental Services<br/>(continued)</b> | <ul style="list-style-type: none"> <li>Select codes are covered at \$0 copayment with no frequency limitation.</li> </ul>   | <ul style="list-style-type: none"> <li>\$0 copay / 1 every 12 months</li> <li>\$0 copay / 2 every 12 months</li> </ul>  |
|  | <p><u>Implant Services:</u><br/>Select codes</p> <ul style="list-style-type: none"> <li>\$0 copay / 1 every 12 months</li> <li>\$0 copay / 1 every 24 months</li> <li>\$0 copay / 1 every 8 years</li> <li>\$0 copay / 1 per lifetime</li> <li>Select codes are covered at \$0 copayment with no</li> </ul> | <ul style="list-style-type: none"> <li>\$0 copay / 6 every 2 months</li> <li>Select codes are covered at \$0 copayment with no frequency limitation.</li> </ul> <p><u>Implant Services:</u><br/>Select codes</p> <ul style="list-style-type: none"> <li>\$0 copay / 1 every 12 months</li> <li>\$0 copay / 1 every 24 months</li> </ul> |

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|  | 2025 (this year)  | 2026 (next year)  |
|--|---|---|
| <b>Dental services –<br/>Comprehensive<br/>Dental Services<br/>(continued)</b> | frequency<br>limitation<br><br><u>Prosthodontics,<br/>fixed services:<br/>Select Codes</u><br><br><ul style="list-style-type: none"> <li>• \$0 copay /1<br/>every 60 months</li> <li>• \$0 copay /1<br/>every 24 months</li> </ul>                  | <ul style="list-style-type: none"> <li>• \$0 copay /<br/>1 every<br/>8 years</li> <li>• \$0 copay /<br/>1 per lifetime</li> <li>• Select codes<br/>are covered at<br/>\$0 copayment<br/>with no<br/>frequency<br/>limitation</li> </ul> |
|  | <u>Oral and<br/>Maxillofacial<br/>Surgery: Select<br/>Codes</u><br><br><ul style="list-style-type: none"> <li>• \$0 copay /1<br/>every 24<br/>months</li> <li>• \$0 copay /<br/>1 per lifetime</li> <li>• \$0 copay /<br/>2 per lifetime</li> </ul> | <u>Prosthodontics,<br/>fixed services:<br/>Select Codes</u><br><br><ul style="list-style-type: none"> <li>• \$0 copay /1<br/>every 60<br/>months</li> <li>• \$0 copay /<br/>1 every<br/>24 months</li> </ul>                            |

# Elderplan For Medicaid Beneficiaries (HMO-POS D-SNP) Annual Notice of Change for 2026 30

|  | 2025 (this year)  | 2026 (next year)  |
|--|---|---|
| <b>Dental services –<br/>Comprehensive<br/>Dental Services<br/>(continued)</b> | <ul style="list-style-type: none"> <li>• \$0 copay / 3 per lifetime</li> <li>• Select codes are covered at \$0 copayment with no frequency limitation</li> </ul>  | <ul style="list-style-type: none"> <li>• Select codes are covered at \$0 copayment</li> </ul>   |
|  | <u>Adjunctive<br/>General Services:</u><br>Select Codes   | <u>Oral and<br/>Maxillofacial<br/>Surgery: Select<br/>Codes</u>   |
|  | <ul style="list-style-type: none"> <li>• \$0 copay / 1 every 6 months</li> <li>• \$0 copay / 1 every 12 months</li> <li>• \$0 copay / 2 every 12 months</li> <li>• Select codes are covered at \$0 copayment</li> </ul> | <ul style="list-style-type: none"> <li>• \$0 copay / 1 every 6 months</li> <li>• \$0 copay / 1 every 12 months</li> <li>• \$0 copay / 1 every 24 months</li> <li>• \$0 copay / 2 every 60 months</li> <li>• \$0 copay / 1 per lifetime</li> <li>• \$0 copay / 2 per lifetime</li> </ul> |

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|   | 2025 (this year)  | 2026 (next year)  |
|---|---|---|
| <p><b>Dental services – Comprehensive Dental Services (continued)</b></p> | <p>with no frequency limitation.</p> <p>For more information about which services are covered please contact Member Services.</p> | <ul style="list-style-type: none"> <li>• \$0 copay / 3 per lifetime</li> <li>• Select codes are covered at \$0 copayment with no frequency limitation</li> </ul> <p><u>Adjunctive General Services:</u><br/>Select Codes</p> <ul style="list-style-type: none"> <li>• \$0 copay / 1 every 7 days</li> <li>• \$0 copay / 1 every 6 months</li> <li>• \$0 copay / 1 every 12 months</li> <li>• \$0 copay / 2 every 12 months</li> </ul> |

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| <b>2025 (this year)</b>  | <b>2026 (next year)</b>  |
|--|--|
| <b>Dental services –<br/>Comprehensive<br/>Dental Services<br/>(continued)</b> | <ul style="list-style-type: none"><li>• Select codes are covered at \$0 copayment with no frequency limitation.</li></ul> <p>For more information about which services are covered please contact Member Services.</p> |

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(HMO-POS D-SNP) Annual Notice of Change for 2026 33**

|  | <b>2025 (this year)</b>  | <b>2026 (next year)</b>  |
|--|--|--|
| <b>Emergency care</b>  | <p>You pay 0% or 20% coinsurance (up to \$110) for each Medicare-covered emergency room visit.</p> <p>*If you are eligible for Medicare cost sharing assistance under Medicaid, you pay \$0.</p> | <p>You pay 0% or 20% coinsurance (up to \$115) for each Medicare-covered emergency room visit.</p> <p>*If you are eligible for Medicare cost sharing assistance under Medicaid, you pay \$0.</p> |
| <b>The Combined In-Network Deductible Applies to the following services:</b> | <p>Cardiac Rehabilitation Services;<br/>Intensive Cardiac Rehabilitation Services;<br/>Pulmonary Rehabilitation Services; SET for PAD Services;<br/>Partial</p>                                  | <p>Cardiac Rehabilitation Services;<br/>Intensive Cardiac Rehabilitation Services;<br/>Pulmonary Rehabilitation Services; SET for PAD Services;<br/>Partial</p>                                  |

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(HMO-POS D-SNP) Annual Notice of Change for 2026 34**

|   | <b>2025 (this year)</b>   | <b>2026 (next year)</b>  |
|---|---|--|
| <p><b>The Combined In-Network Deductible Applies to the following services: (continued)</b></p> | <p>Hospitalization; Home Health Services; Primary Care Physician Services; Chiropractic Services; Occupational Therapy Services; Physician Specialist Services; Mental Health Specialty Services Individual and Group Sessions; Podiatry Services; Other Health Care Professional; Psychiatric Services Individual and Group Sessions; Physical Therapy and Speech-</p> | <p>Hospitalization; Intensive Outpatient Program Services; Home Health Services; Primary Care Physician Services; Chiropractic Services; Occupational Therapy Services; Physician Specialist Services; Mental Health Specialty Services Individual and Group Sessions; Podiatry Services; Other Health Care Professional; Psychiatric Services</p> |

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|   | <b>2025 (this year)</b>  | <b>2026 (next year)</b>   |
|---|--|---|
| <p><b>The Combined In-Network Deductible Applies to the following services: (continued)</b></p> | <p>Language Pathology Services; Additional Telehealth Services; Diagnostic Procedures/Tests/ Lab Services; Therapeutic Radiological Services; Outpatient X-Ray Services; Outpatient Hospital Services; Observation Services; Ambulatory Surgical Center (ASC) Services; Outpatient Substance Abuse Individual and Group Sessions; Outpatient Blood</p> | <p>Individual and Group Sessions; Physical Therapy and Speech-Language Pathology Services; Additional Telehealth Services; Diagnostic Procedures/Tests/ Lab Services; Therapeutic Radiological Services; Outpatient X-Ray Services; Outpatient Hospital Services; Observation Services; Ambulatory Surgical Center (ASC) Services; Outpatient</p> |

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|  | <b>2025 (this year)</b>   | <b>2026 (next year)</b>   |
|--|---|---|
| <b>The Combined In-Network Deductible Applies to the following services: (continued)</b> | Services; Ground Ambulance Services; Air Ambulance Services; Prosthetics/Medical Supplies; Dialysis Services; Kidney Disease Education Services; Glaucoma Screening; Diabetes Self-Management Training. | Substance Abuse Individual and Group Sessions; Outpatient Blood Services; Ground Ambulance Services; Air Ambulance Services; Prosthetics/Medical Supplies; Dialysis Services; Kidney Disease Education Services; Glaucoma Screening; Diabetes Self-Management Training. |
| <b>Inpatient hospital stays</b>  | <b>In Network:</b><br>In 2025 the amounts for each benefit period are \$0* OR: \$1,676  | <b>In Network:</b><br>In 2025 the amounts for each benefit period are \$0* OR: \$1,676  |

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|   | <b>2025 (this year)</b>  | <b>2026 (next year)</b>  |
|---|--|--|
| <b>Inpatient hospital stays (continued)</b> | <p>deductible. Days 1-60: \$0 copayment per day. Days 61-90: \$419 copayment per day. Days 91 and beyond: \$838 copayment per lifetime reserve day. Beyond lifetime reserve days: you pay all costs.</p> <p>Authorization is required.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you</p> | <p>deductible. Days 1-60: \$0 copayment per day. Days 61-90: \$419 copayment per day. Days 91 and beyond: \$838 copayment per lifetime reserve day. Beyond lifetime reserve days: you pay all costs.</p> <p>Authorization is required.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you</p> |

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|   | <b>2025 (this year)</b>   | <b>2026 (next year)</b>   |
|---|---|---|
| <b>Inpatient hospital stays (continued)</b> | <p>would pay at a network hospital.</p> <p>*If you are eligible for Medicare cost sharing assistance under Medicaid, you pay \$0.</p> | <p>would pay at a network hospital.</p> <p>*If you are eligible for Medicare cost sharing assistance under Medicaid, you pay \$0.</p> <p>These are 2025 cost-sharing amounts and may change for 2026. Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) will provide updated rates at <a href="http://www.elderplan.org">www.elderplan.org</a> as soon as they are released.</p> |

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|   | <b>2025 (this year)</b>  | <b>2026 (next year)</b>  |
|---|--|--|
| <b>Inpatient services in a psychiatric hospital</b> | <p><b>In Network:</b><br/>In 2025, the amounts for each benefit period are \$0* OR: \$1,676 deductible.</p> <p>Days 1-60: \$0 copayment per day.</p> <p>Days 61-90: \$419 copayment per day.</p> <p>Days 91 and beyond: \$838 copayment per lifetime reserve day.</p> <p>Beyond lifetime reserve days: you pay all costs.</p> <p>You pay 0% or 20% of the Medicare approved amount for mental health</p> | <p><b>In Network:</b><br/>In 2025, the amounts for each benefit period are \$0* OR: \$1,676 deductible.</p> <p>Days 1-60: \$0 copayment per day.</p> <p>Days 61-90: \$419 copayment per day.</p> <p>Days 91 and beyond: \$838 copayment per lifetime reserve day.</p> <p>Beyond lifetime reserve days: you pay all costs.</p> <p>You pay 0% or 20% of the Medicare approved amount for mental health</p> |

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|  | <b>2025 (this year)</b>  | <b>2026 (next year)</b>  |
|--|--|--|
| <p><b>Inpatient services in a psychiatric hospital (continued)</b></p> | <p>services you get from doctors and other providers while you're a hospital inpatient. Authorization is required.</p> <p>*If you are eligible for Medicare cost sharing assistance under Medicaid, you pay \$0.</p> | <p>services you get from doctors and other providers while you're a hospital inpatient. Authorization is required.</p> <p>*If you are eligible for Medicare cost sharing assistance under Medicaid, you pay \$0.</p> <p>These are 2025 cost-sharing amounts and may change for 2026. Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) will provide updated rates at <a href="http://www.elderplan.org">www.elderplan.org</a></p> |

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|   | <b>2025 (this year)</b>  | <b>2026 (next year)</b>  |
|---|--|--|
| <b>Inpatient services in a psychiatric hospital (continued)</b> |  | as soon as they are released.  |
| <b>Medicare Part B prescription drugs</b>                       | <p><b>In Network:</b><br/>You pay 0% or 20% coinsurance for Medicare Part B prescription drugs. *</p> <p>You pay up to \$35 for Medicare Part B Insulin Drugs.</p> <p>Medicare Part B Chemotherapy/ Radiation Drugs may require authorization.</p> <p>Authorization may be required for certain drugs.</p> | <p><b>In Network:</b><br/>You pay 0% or 20% coinsurance for Medicare Part B prescription drugs. *</p> <p>You pay up to \$35 for Medicare Part B Insulin Drugs.</p> <p>Medicare Part B Chemotherapy/ Radiation Drugs authorization is NOT required.</p> <p>Authorization may be required for certain drugs.</p> |

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|   | <b>2025 (this year)</b>  | <b>2026 (next year)</b>  |
|---|--|--|
| <b>Medicare Part B prescription drugs (continued)</b> | *If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.   | *If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.   |
| <b>Skilled Nursing Facility (SNF) Care</b>            | <p><b>In Network:</b><br/>In 2025, the amounts for each benefit period after at least a 3-day Medicare covered inpatient hospital stay are \$0*</p> <p><b>OR:</b><br/>Days 1 - 20: \$0 per day<br/>Days 21 - 100: \$209.50 copayment per day</p> | <p><b>In Network:</b><br/>In 2025, the amounts for each benefit period after at least a 3-day Medicare covered inpatient hospital stay are \$0*</p> <p><b>OR:</b><br/>Days 1 - 20: \$0 per day<br/>Days 21 - 100: \$209.50 copayment per day</p> |

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|   | 2025 (this year)   | 2026 (next year)   |
|---|--|--|
| <p><b>Skilled Nursing Facility (SNF) Care (continued)</b></p> | <p>Days 101 and beyond: you pay all costs.</p> <p>Authorization is required.</p> <p>*If you are eligible for Medicare cost sharing assistance under Medicaid, you pay \$0.</p> | <p>Days 101 and beyond: you pay all costs.</p> <p>Authorization is required.</p> <p>*If you are eligible for Medicare cost sharing assistance under Medicaid, you pay \$0.</p> <p>These are 2025 cost-sharing amounts and may change for 2026. Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) will provide updated rates at <a href="http://www.elderplan.org">www.elderplan.org</a> as soon as they are released.</p> |

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|                                 | 2025 (this year)   | 2026 (next year)   |
|---------------------------------|--|--|
| <b>Urgently needed services</b> | <p>You pay 0% or 20% coinsurance (up to \$45) for each visit *</p> <p>If you are admitted to the hospital within 24 hours for the same condition, there is no coinsurance.</p> <p>*If you are eligible for Medicare cost sharing assistance under Medicaid, you pay \$0.</p> | <p>You pay 0% or 20% coinsurance (up to \$40) for each visit *</p> <p>If you are admitted to the hospital within 24 hours for the same condition, there is no coinsurance.</p> <p>*If you are eligible for Medicare cost sharing assistance under Medicaid, you pay \$0.</p> |

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## Section 1.6 Changes to Part D Drug Coverage

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### Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-800-353-3765 (TTY users call 711) for more information.

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## Section 1.7 Changes to Prescription Drug Benefits & Costs

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### Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We have included a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells about your drug costs. If you get Extra Help and didn't get this material with this packet, call Member Services at 1-800-353-3765 (TTY users call 711) and ask for the *LIS Rider*.

### Drug Payment Stages

There are 3 **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Part D drugs until you reach the yearly deductible.

- ***Stage 2: Initial Coverage***

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You

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generally stay in this stage until your year-to-date total drug costs reach \$2,100.

- ***Stage 3: Catastrophic Coverage***

This is the third and final drug payment stage. In this stage, you pay for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

The table shows your cost per prescription during this stage.

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|                          | 2025 (this year)  | 2026 (next year)  |
|--------------------------|---|---|
| <b>Yearly Deductible</b> | <p>The Part D deductible is \$590.</p> <p>If you receive “Extra Help” to pay your prescription drugs, your deductible amount will be \$0.</p> | <p>The Part D deductible is \$615.</p> <p>If you receive “Extra Help” to pay your prescription drugs, your deductible amount will be \$0.</p> |

## Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month supply filled at a network pharmacy with standard cost sharing.

Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs, go to Chapter 6 of your *Evidence of Coverage*.

Once you’ve paid \$2,100 out of pocket for covered Part D drugs, you’ll move to the next stage (the Catastrophic Coverage Stage).

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|                               | <b>2025 (this year)</b>  | <b>2026 (next year)</b>  |
|-------------------------------|--|--|
| <b>Initial Coverage Stage</b> | <p><b>Standard retail cost sharing (in-network)</b><br/>(up to a 90-day supply) * † Ω</p> <p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is:</p> <p><b>Tier 1:</b><br/>Depending on your “Extra Help” You Pay:</p> <p><b>For generic drugs</b> (including brand drugs treated as generic):<br/>\$0 copay or<br/>\$1.60 copay or<br/>\$4.90 copay or</p> | <p><b>Standard retail cost sharing (in-network)</b><br/>(up to a 90-day supply) * † Ω</p> <p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is:</p> <p><b>Tier 1:</b><br/>Depending on your “Extra Help” You Pay:</p> <p><b>For generic drugs</b> (including brand drugs treated as generic):<br/>\$0 copay or<br/>\$1.60 copay or<br/>\$5.10 copay or</p> |

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|   | 2025 (this year)   | 2026 (next year)   |
|---|--|--|
| <b>Initial Coverage Stage (continued)</b> | 25% of the total cost.   | 25% of the total cost.   |
|   | <b>For all other drugs:</b>  | <b>For all other drugs:</b>  |
|   | \$0 copay or   | \$0 copay or   |
|   | \$4.80 copay or  | \$4.90 copay or  |
|   | \$12.15 copay or   | \$12.65 copay or   |
|   | 25% of the cost.   | 25% of the cost.   |
|   | *60-Day supply is also available for Standard Retail.  | *60-Day supply is also available for Standard Retail.  |
|   | <b>Mail-order cost sharing (up to 90-day supply) †</b>   | <b>Mail-order cost sharing (up to 90-day supply) †</b>   |
|   | <b>Ω</b> during the Initial Coverage Stage For:  | <b>Ω</b> during the Initial Coverage Stage For:  |
|   | <b>Tier 1:</b>   | <b>Tier 1:</b>   |
|   | Depending on your level of “Extra Help” You Pay: <b>For generic drugs</b> (including brand drugs | Depending on your level of “Extra Help” You Pay: <b>For generic drugs</b> (including brand drugs |

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|   | 2025 (this year)   | 2026 (next year)   |
|---|--|--|
| <b>Initial Coverage Stage (continued)</b> | <p>treated as generic):<br/>\$0 copay or<br/>\$1.60 copay or<br/>\$4.90 copay or<br/>25% of the cost.</p> <p><b>For all other drugs:</b><br/>\$0 copay or<br/>\$4.80 copay or<br/>\$12.15 copay or<br/>25% of the cost.</p> <p>†NDS – Non-Extended Days Supply. Certain specialty drugs will be limited up to a 30-day supply per fill.</p> <p><b>Ω</b> – You will not pay more than \$35 for a one-month supply of each insulin</p> | <p>treated as generic):<br/>\$0 copay or<br/>\$1.60 copay or<br/>\$5.10 copay or<br/>25% of the cost.</p> <p><b>For all other drugs:</b><br/>\$0 copay or<br/>\$4.90 copay or<br/>\$12.65 copay or<br/>25% of the cost.</p> <p>†NDS – Non-Extended Days Supply. Certain specialty drugs will be limited up to a 30-day supply per fill.</p> <p><b>Ω</b> – You will not pay more than \$35 for a one-month supply of each insulin</p> |

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|   | 2025 (this year)   | 2026 (next year)   |
|---|--|--|
| <b>Initial Coverage Stage (continued)</b> | product covered by our plan, no matter the cost-sharing for Part B and D drugs, even if you have not paid your deductible. | product covered by our plan, no matter the cost-sharing for Part B and D drugs, even if you have not paid your deductible. |

## Changes to the Catastrophic Coverage Stage

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6, in your *Evidence of Coverage*.

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## SECTION 2 Administrative Changes

|   | 2025 (this year)   | 2026 (next year)  |
|---|--|---|
| <b>Medicare Prescription Payment Plan</b> | The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option. | If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.<br><br>To learn more about this payment option, call us at 1-866-490-2102 (TTY users call 711 or visit <a href="http://www.medicare.gov">www.medicare.gov</a> ). |

## SECTION 3 How to Change Plans

**To stay in Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP), you don't need to do anything.** Unless you sign up for

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a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP).

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP).
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP).
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Services at 1-800-353-3765 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 4).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit [www.medicare.gov](http://www.medicare.gov), check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 6), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Elderplan, Inc. offers other Medicare health plans. These other plans can differ in coverage, monthly plan premiums, and cost-sharing amounts.

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## Section 3.1 Deadlines for Changing Plans

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People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) between January 1 – March 31, 2026.

## Section 3.2 Are there other times of the year to make a change?

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In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option,

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Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or

- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

### **SECTION 4 Get Help Paying for Prescription Drugs**

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs, including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.

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- Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call, 1-800-325-0778.
- Your State Medicaid office.
- **Help from your state’s pharmaceutical assistance program (SPAP).** New York has a program called Elderly Pharmaceutical Insurance Coverage Program (EPIC) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit [shiphelp.org](http://shiphelp.org), or call 1-800-MEDICARE.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the New York AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you’re currently enrolled, how to continue getting help, call 1-800-542-2437. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

## **Elderplan For Medicaid Beneficiaries (HMO-POS D-SNP) Annual Notice of Change for 2026 58**

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- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate the Medicare Prescription Payment Plan, regardless of income level. To learn more about this payment option, call us at 866-490-2102 (TTY users call 711) or visit [www.medicare.gov](http://www.medicare.gov).

### **SECTION 5 Questions?**

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#### **Get Help from Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP)**

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- **Call Member Services at 1-800-353-3765. (TTY users call 711.)**

We're available for phone calls 8 a.m. to 8 p.m., 7 days a week. Calls to these numbers are free.

## **Elderplan For Medicaid Beneficiaries (HMO-POS D-SNP) Annual Notice of Change for 2026 59**

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- **Read your 2026 *Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at [www.elderplan.org](http://www.elderplan.org) or call Member Services at 1-800-353-3765 (TTY users call 711) to ask us to mail you a copy.

- **Visit [www.elderplan.org](http://www.elderplan.org)**

Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

### **Get Free Counseling about Medicare**

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In New York, the SHIP is called The Office for the Aging's Health Insurance Information, Counseling and Assistance Program (HIICAP).

Call HIICAP to get free personalized health insurance counseling. They can help you understand your Medicare and Medicaid plan choices and answer questions about switching

## **Elderplan For Medicaid Beneficiaries (HMO-POS D-SNP) Annual Notice of Change for 2026 60**

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plans. Call HIICAP at 1-(212)-602-4180 (Inside the following: 5 boroughs of NYC) or 1-800-701-0501 (Outside the 5 boroughs of NYC) Learn more about HIICAP by visiting <https://aging.ny.gov/programs/medicare-and-health-insurance>.

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### **Get Help from Medicare**

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- **Call 1-800-MEDICARE (1-800-633-4227)**  
You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.
- **Chat live with [www.medicare.gov](http://www.medicare.gov)**  
You can chat live at [www.medicare.gov/talk-to-someone](http://www.medicare.gov/talk-to-someone).
- **Write to Medicare**  
You can write to Medicare at PO Box 1270, Lawrence, KS 66044
- **Visit [www.medicare.gov](http://www.medicare.gov)**  
The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.
- **Read *Medicare & You 2026***  
The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at

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[www.medicare.gov](http://www.medicare.gov) or by calling 1-800-MEDICARE  
(1-800-633-4227). TTY users can call 1-877-486-2048.

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## **Get Help from Medicaid**

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Call the New York State Department of Health (Social Services) HRA Medicaid Helpline at 1-888-692-6116. TTY users 711 for help with Medicaid enrollment or benefit questions. You can also visit <https://www.nyc.gov/site/hra/help/health-assistance.page>

For New York State Local Department Social Services visit [https://www.health.ny.gov/health\\_care/medicaid/ldss.htm](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, 46<sup>th</sup> Floor  
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>.

**English:** Elderplan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a non-English language or require interpretation assistance, language assistance services and appropriate auxiliary aids are available to you free of charge. If you need these services or have questions about our plan, call 1-800-353-3765 (TTY: 711).

**Spanish:** Elderplan, Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: Si usted habla en un idioma que no es inglés o requiere asistencia de interpretación, tiene a su disposición servicios de asistencia lingüística y las ayudas auxiliares adecuadas de forma gratuita. Si necesita estos servicios o tiene preguntas sobre nuestro plan, llame al 1-800-353-3765 (TTY: 711).

**Chinese:** Elderplan, Inc. 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障情況或性別而歧視任何人。請注意：如果您說英語以外的語言或需要口譯協助，我們將免費為您提供語言協助服務和適當的輔助工具。如果您需要這些服務或對我們的計劃有疑問，請致電 1-800-353-3765 (TTY: 711)。

**Albanian:** Elderplan, Inc. u përmbahet ligjeve të zbatueshme federale për të drejtat civile, ndaj nuk ju diskriminon në bazë të racës, ngjyrës, origjinës kombëtare, moshës, aftësive të kufizuara ose seksit. VËMENDJE: Nëse flisni një gjuhë tjetër që nuk është anglisht ose nëse keni nevojë për shërbime përkthimi, për ju ofrohen falas shërbime të ndihmës gjuhësore dhe mjete ndihmëse të përshtatshme. Nëse keni nevojë për këto shërbime ose nëse keni pyetje rreth planit tonë, telefononi 1-800-353-3765 (TTY: 711).

#### Arabic

لقوانين الحقوق المدنية الفيدرالية المعمول بها ولا تميز على أساس العرق أو اللون أو الأصل Elderplan Inc. تمتثل القومي أو العمر أو الإعاقة أو الجنس. تنبيه: إذا كنت تتحدث لغة غير الإنجليزية أو تحتاج إلى مساعدة في الترجمة الفورية، فإن خدمات المساعدة اللغوية والمساعدات المعينة المناسبة متاحة لك مجاناً. إذا كنت بحاجة إلى هذه الخدمات أو كانت لديك أسئلة حول خطتنا، فاتصل بالرقم 1-800-353-3765 (TTY: 711).

**Bengali:** Elderplan, Inc. প্রযোজ্য ফেডারেল নাগরিক অধিকার আইন মেনে চলে এবং জাতি, বর্ণ, জাতীগত উৎপত্তি, বয়স, অক্ষমতা বা লিঙ্গের ভিত্তিতে বৈষম্য করে না। লক্ষ্য করুন: যদি আপনি ইংরেজি ছাড়া অন্য কোনো ভাষায় কথা বলেন বা দোভাষী সহায়তার প্রয়োজন হয়, আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং প্রয়োজনীয় সহায়ক উপকরণ উপলব্ধ আছে। আপনার যদি এই পরিষেবাগুলির প্রয়োজন হয় বা আমাদের পরিকল্পনা সম্পর্কে প্রশ্ন থাকে তবে 1-800-353-3765 (TTY: 711) নম্বরে ফোন করুন।

**French:** Elderplan, Inc. se conforme aux lois fédérales applicables en matière de droits civils et ne fait aucune discrimination fondée sur la race, la couleur, l'origine nationale, l'âge, le handicap ou le sexe. ATTENTION : Si vous parlez une langue autre que l'anglais ou si vous avez besoin d'une assistance d'interprétation, des services d'assistance linguistique et des aides auxiliares appropriées sont à votre disposition gratuitement. Si vous avez besoin de ces services ou si vous avez des questions sur notre régime d'assurance maladie, appelez le 1-800-353-3765 (TTY : 711).

**German:** Elderplan, Inc. hält alle geltenden Bundesbürgerrechtsgesetze ein und diskriminiert nicht aufgrund von Ethnie, Hautfarbe, nationaler Herkunft, Alter, Behinderung oder Geschlecht. HINWEIS: Wenn Sie eine andere als die englische Sprache sprechen oder einen Dolmetscher benötigen, stehen Ihnen Sprachassistentendienste und geeignete Hilfsmittel kostenlos zur Verfügung. Falls Sie solche Dienste benötigen oder Fragen zu unserem Plan haben, rufen Sie uns bitte unter der Nummer +1-800-353-3765 (TTY: 711) an.

**Greek:** Η Elderplan, Inc. συμμορφώνεται με τους ισχύοντες ομοσπονδιακούς νόμους περί πολιτικών δικαιωμάτων και δεν κάνει διακρίσεις με βάση τη φυλή, το χρώμα, την εθνική καταγωγή, την ηλικία, την αναπηρία ή το φύλο. ΠΡΟΣΟΧΗ: Αν μιλάτε άλλη γλώσσα εκτός από τα αγγλικά ή χρειάζεστε τη βοήθεια διερμηνείας, παρέχονται δωρεάν υπηρεσίες γλωσσικής υποστήριξης και κατάλληλα βοηθητικά μέσα. Εάν χρειάζεστε αυτές τις υπηρεσίες ή έχετε ερωτήσεις σχετικά με το πρόγραμμά μας, καλέστε στο 1-800-353-3765 (TTY: 711).

**Haitian Creole:** Elderplan, Inc. konfòme l avèk lwa Federal sou dwa sivil ki aplikab yo epi li pa fè diskriminasyon sou baz ras, koulè, orijin nasyonan, laj, andikap oswa sèks. ATANSYON: Si ou pale yon lang ki pa Angle oswa ou bezwen asistans entèprèt, sèvis asistans lang ak èd oksilyè ki apwopriye yo disponib pou ou gratis. Si ou bezwen sèvis sa yo oswa ou gen kesyon sou plan nou an, rele 1-800-353-3765 (TTY: 711).

**Hindi:** Elderplan, Inc. लागू संघीय नागरिक अधिकार कानूनों का अनुपालन करता है और नस्ल, रंग, राष्ट्रीय मूल, उम्र, विकलांगता या लिंग के आधार पर भेदभाव नहीं करता है। ध्यान दें: यदि आप एक गैर-अंग्रेज़ी भाषा बोलते हैं या आपको भाषांतरण सहायता की आवश्यकता है, तो भाषा सहायता सेवाएँ और उपयुक्त सहायक उपकरण आपके लिए निःशुल्क उपलब्ध हैं। यदि आपको इन सेवाओं की आवश्यकता है या हमारी योजना के बारे में प्रश्न हैं, तो 1-800-353-3765 (TTY: 711) पर कॉल करें।

**Italian:** Elderplan, Inc. è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso. ATTENZIONE: Se parla una lingua diversa dall'inglese o ha bisogno dell'assistenza di un interprete, può usufruire gratuitamente di servizi di assistenza linguistica e di appositi supporti ausiliari. Se necessita di questi servizi o ha domande sul nostro piano, chiami il numero 1-800-353-3765 (TTY: 711).

**Japanese:** Elderplan, Inc. は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害、性別に基づいて差別しません。注意：英語以外の言語を話す場合や通訳のサポートが必要な場合は、言語サポートサービスと適切な補助器具を無料でご利用いただけます。これらのサービスが必要な場合、または当社のプランについてご質問がある場合は、1-800-353-3765 (TTY: 711) までお電話ください。

**Korean:** Elderplan, Inc.는 해당 연방 민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 근거로 차별하지 않습니다. 주의: 영어 이외의 언어를 구사하거나 통역 지원이 필요한 경우 언어 지원 서비스 및 적절한 보조 장치를 무료로 이용할 수 있습니다. 이러한 서비스가 필요하거나 플랜에 대해 질문이 있는 경우 1-800-353-3765 (TTY: 711) 로 전화하십시오.

**Polish:** Elderplan, Inc. przestrzega obowiązujących federalnych przepisów dotyczących praw obywatelskich i nie dyskryminuje ze względu na rasę, kolor skóry, pochodzenie narodowe, wiek, niepełnosprawność ani płeć. UWAGA: Jeśli mówisz w języku innym niż angielski lub potrzebujesz pomocy tłumacza, możesz bezpłatnie skorzystać z usług pomocy językowej i odpowiednich narzędzi pomocniczych. Jeśli potrzebujesz tych usług lub masz pytania dotyczące naszego planu, zadzwoń pod numer 1-800-353-3765 (TTY: 711).

**Portuguese:** A Elderplan, Inc. cumpre as leis federais de direitos civis aplicáveis e não discrimina com base em raça, cor, nacionalidade, idade, deficiência ou sexo. ATENÇÃO: Se fala uma língua diferente do inglês ou necessita de assistência de interpretação, estão disponíveis gratuitamente serviços de assistência linguística e recursos auxiliares apropriados. Se precisar destes serviços ou tiver dúvidas sobre o nosso plano, ligue para 1-800-353-3765 (TTY: 711).

**Punjabi:** Elderplan, Inc. ਲਾਗੂ ਸੰਘੀ ਨਾਗਰਿਕ ਅਧਿਕਾਰ ਕਾਨੂੰਨਾਂ ਦੀ ਪਾਲਣਾ ਕਰਦਾ ਹੈ ਅਤੇ ਨਸਲ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਪਾਹਜਤਾ, ਜਾਂ ਲਿੰਗ ਦੇ ਆਧਾਰ 'ਤੇ ਵਿਤਕਰਾ ਨਹੀਂ ਕਰਦਾ ਹੈ। ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਕੋਈ ਅੰਗਰੇਜ਼ੀ ਤੋਂ ਬਿਨਾਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ ਜਾਂ ਵਿਆਖਿਆ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੁੰਦੀ ਹੈ, ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਜੇ ਤੁਹਾਨੂੰ ਇਹਨਾਂ ਸੇਵਾਵਾਂ ਦੀ ਲੋੜ ਹੈ ਜਾਂ ਸਾਡੀ ਯੋਜਨਾ ਬਾਰੇ ਤੁਹਾਡੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ 1-800-353-3765 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

**Russian:** Компания Elderplan, Inc. соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола. ВНИМАНИЕ: Если вы не говорите на английском языке или вам нужна помощь переводчика, вам будут бесплатно предоставлены услуги языковой помощи и соответствующие вспомогательные средства. Если вам нужны такие услуги или у вас есть вопросы о нашем плане, позвоните по номеру 1-800-353-3765 (TTY: 711).

**Tagalog:** Sumusunod ang Elderplan, Inc. sa naaangkop na mga batas sa Pederal na mga karapatang sibil at hindi nandiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan, o kasarian. ATENSYON: Kung nagsasalita ka ng wikang hindi Ingles o nangangailangan ng tulong sa interpretasyon, ang mga serbisyo ng tulong sa wika at naaangkop na mga pantulong na tulong ay magagamit mo nang walang bayad. Kung kailangan mo ang mga serbisyo ng ito o may mga tanong tungkol sa aming plano, tawagan ang 1-800-353-3765 (TTY: 711).

## Urdu

Elderplan/HomeFirst قابل اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے اور نسل، رنگ، قومیت، عمر، معذوری، یا جنس کی بنیاد پر امتیازی سلوک نہیں کرتا۔ توجہ: اگر آپ غیر انگریزی زبان بولتے ہیں یا تشریح میں مدد کی ضرورت ہے تو، زبان کی مدد کی خدمات اور مناسب معاون امداد آپ کے لئے مفت دستیاب ہیں۔ اگر آپ کو ان خدمات کی ضرورت ہے یا ہمارے منصوبے کے بارے میں سوالات ہیں تو، (TTY: 711) 1-800-353-3765 پر کال کریں۔

**Vietnamese:** Elderplan, Inc. tuân thủ luật dân quyền Liên bang hiện hành và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, tình trạng khuyết tật hoặc giới tính. CHÚ Ý: Nếu quý vị nói ngôn ngữ không phải tiếng Anh hoặc cần được hỗ trợ thông dịch thì chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ và các phương tiện phụ trợ phù hợp miễn phí cho quý vị. Nếu quý vị cần những dịch vụ này hoặc có thắc mắc về chương trình của chúng tôi, hãy gọi số 1-800-353-3765 (TTY: 711).

## Yiddish

Elderplan, Inc. פאָלגט די אָנווענדלעכע פעדעראלע ציווילע רעכט געזעצן און דיסקרימינירט נישט אויף דער באַזע פון ראַסע, קאָליר, נאַציאָנאַלער אָפּשטאַם, עלטער, דיסאַביליטי, אָדער געשלעכט. ופּמערקזאַמקייט: אויב איר רעדט אַ נישט-ענגלישע שפּראַך אָדער דאַרפֿט הילף מיט איבערזעצונג, זענען שפּראַך הילף באַדינונגען און פּאַסיק הילפּסמיטלען בנימצא פֿאַר אַיך אָן קיין אָפּצאָל. אויב איר דאַרפֿט די סערוויסעס אדער האָט פֿראַגעס וועגן אונדזער פּלאַן, רופֿט אָן 1-800-353-3765 (TTY: 711)