2027

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Leading the way to great care.℠



Summary of Benefits

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

January 1, 2027 to December 31, 2027

H3347_EP18219_M

Summary of Benefits – **Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) 2027**

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, 2027 – December 31, 2027

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

About Elderplan

Elderplan is a proud participating agency of MJHS Health System. 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 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 a participating agency of MJHS, is that the health system also includes: MJHS Home Care, MJHS Hospice and Palliative Care, as well as 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 for Medicare beneficiaries who also have Medicaid, that covers medical, hospital, and prescription drugs—all in one simple plan.

You can see any dentist or specialist in or out-of-network and take advantage of a monthly OTC benefit. In addition, you'll also receive a Flex card to help cover out-of-pocket expenses for dental, vision, hearing, and fitness services.

This plan includes comprehensive dental coverage—with a larger network of providers through our dental partner DentaQuest—so you can get the care you need more easily.

You'll also have the support of a dedicated Care Manager, enjoy a gym membership to stay active, earn rewards through our Wellness Incentive Program, and have access to our award-winning Member-to-Member program.

Elderplan. Leading the way to great care.

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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‡	**$375** every year
Over-the-Counter (OTC) Benefits	**$200** every month
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 $37.90 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 the SSBCI benefit (expanded OTC). Examples include, but are not limited to, Cardiovascular Disorders, Diabetes, Arthritis, Chronic Kidney Disease, Chronic Respiratory Disease (e.g., COPD). There are other eligible conditions not listed. Standards may vary for this benefit.

‡Flex Card benefit offers $375 allowance to use in 2027on 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 2027 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, Putnam, Queens, Richmond 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, Putnam, Queens, Richmond 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 Plus (QMB+):** 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.

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 $37.90	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.

Elderplan For Medicaid Beneficiaries (HMO-POS D-SNP)		
Part B Deductible	$0 or $283	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 2026 cost-sharing amounts and may change for 2027. Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) will provide updated rates at www.elderplan.org as soon as they are released.

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

Elderplan For Medicaid Beneficiaries (HMO-POS D-SNP)		
Combined Maximum Out-of-Pocket	$9,850 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 2026 the amounts for each benefit period are $0* or: $1,736 deductible. Days 1–60: $0 copayment per day. Days 61–90: $434 copayment per day. Days 91 and beyond: $868 copayment per lifetime reserve day.	Authorization is required.

*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 hospital care *(continued)*	Inpatient Hospital Services *(continued)*	Beyond lifetime reserve days: you pay all costs. These are 2026 cost-sharing amounts and may change for 2027. Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) will provide updated rates at www.elderplan.org as soon as they are released.	

*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 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 screenings • Alcohol misuse screenings & counseling • Bone mass measurements • Cardiovascular disease screenings • Cardiovascular disease (behavioral therapy) • Cervical & vaginal cancer screenings • Colorectal cancer screenings - Blood-based biomarker tests - Colonoscopies - Computed tomography (CT) colonography - Fecal occult blood tests - Flexible sigmoidoscopies - Multi-target stool DNA tests • Counseling to prevent tobacco use & tobacco-caused disease • Depression screenings	

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)*	• Diabetes screenings • Diabetes self-management training • Glaucoma screenings • Hepatitis B shots • Hepatitis B virus (HBV) infection screenings • Hepatitis C virus screenings • HIV screenings • Lung cancer screenings • Mammograms (screening) • Medical nutrition therapy services • Medicare Diabetes Prevention Program • Obesity behavioral therapy • One-time "Welcome to Medicare" preventive visit • Pre-exposure prophylaxis (PrEP) for HIV prevention • Prostate cancer screenings • 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 $115) 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 $40) 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. Authorization may be required for Supplemental Comprehensive Dental Services

Supplemental Diagnostic, Preventive & Comprehensive Dental Services

In-Network and Out-of-Network Combined

Code	Procedure Name	Frequency Limitations	Copayment
Oral Exams			
D0120	Periodic oral evaluation – established patient	One of (D0120) per 6 Month(s) per patient	$0 copayment
D0140	Limited oral evaluation–problem focused	One every month	$0 copayment
D0150	Comprehensive oral evaluation – new or established patient	One of (D0150) every 6 months per provider or location	$0 copayment
D0160	Detailed and extensive oral evaluation – problem focused, by report	One of (D0160) per 90 Day(s) per provider or location. One of (D9991) per 60 Day(s) per provider or location	$0 copayment
D0170	Re-evaluation, limited problem focused	One every 6 months	$0 copayment
D0180	Comprehensive periodontal evaluation – new or established patient	One every 6 months	$0 copayment
D0190	Screening of a patient	One of (D0190, D0191) per 10 Day(s) per provider and location	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral Exams			
D0191	Assessment of a patient	One of (D0190, D0191) per 10 Day(s) per provider and location	$0 copayment
X-Rays			
D0210	Intraoral – comprehensive series of radiographic images	One of (D0210, D0330) per 36 Month(s) per patient	$0 copayment
D0220	Intraoral – periapical first radiographic image	3 of (D0220) per 6 Month(s) per patient	$0 copayment
D0230	Intraoral – periapical each additional radiographic image	The total fee for additional intraoral films may not exceed the total fee allowed for a complete intraoral series.	$0 copayment
D0240	Intraoral – occlusal radiographic image	One of (D0240) per 6 Month(s) per patient, same arch	$0 copayment
D0250	Extra-oral – 2d projection radiographic image created using a stationary radiation source, and detector	Two of (D0250) per 1 Week(s) per patient	$0 copayment
D0251	Extra-oral posterior dental radiographic image	Two of (D0251) per 1 Week(s) per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
X-Rays			
D0270	Bitewing – single radiographic image	3 of (D0270, D0272, D0273, D0274) per 12 Month(s) per patient	$0 copayment
D0272	Bitewings – two radiographic images	3 of (D0270, D0272, D0273, D0274) per 12 Month(s) per patient	$0 copayment
D0273	Bitewings – three radiographic images	3 of (D0270, D0272, D0273, D0274) per 12 Month(s) per patient	$0 copayment
D0274	Bitewings – four radiographic images	3 of (D0270, D0272, D0273, D0274) per 12 Month(s) per patient	$0 copayment
D0277	Vertical bitewings – 7 to 8 films	One every 6 months	$0 copayment
D0310	Saliography	Two of (D0310) per 1 Week(s) per patient	$0 copayment
D0320	Temporomandibular joint arthogram, including injection	Covered	$0 copayment
D0321	Other temporomandibular joint films, by report	Two of (D0321) per 12 Month(s) per patient	$0 copayment
D0330	Panoramic radiographic image	One of (D0210, D0330) per 36 Month(s) per patient	$0 copayment
D0340	Cephalometric radiographic image	One of (D0340) per 36 Month(s) per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
X-Rays			
D0350	2d oral/facial photographic image obtained intra-orally or extra-orally	Two of (D0350) per 6 Month(s) per patient	$0 copayment
D0364	Cone beam CT capture and interpretation with limited field of view, less than one whole jaw	Capture of Cone beam CT with interpretation of such- limited to less than whole jaw	$0 copayment
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	Capture of Cone beam CT with interpretation of such- limited to mandibular arch.	$0 copayment
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	Capture of Cone beam CT with interpretation of such- limited to maxillary arch (without cranium)	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
X-Rays			
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	A panoramic radiograph (D0330) or similar film, along with documentation of medical necessity, must be submitted with requests for prior approval. Approval is limited to those cases demonstrating significant risk for a complication such as nerve injury or jaw fracture as well as pathology or trauma workups and implants	$0 copayment
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	Capture of Cone beam CT with interpretation of such – limited to TMJ series (2 or more exposures)	$0 copayment
D0372	Intraoral tomosynthesis – comprehensive series of radiographic images	One of (D0372) every 36 months per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
X-Rays			
D0373	Intraoral tomosynthesis – bitewing radiographic image	One of (D0373) every 12 months per patient	$0 copayment
D0374	Intraoral tomosynthesis – periapical radiographic image	One of (D0374) every 12 months per patient	$0 copayment
D0387	Intraoral tomosynthesis – comprehensive series image capture	Covered	$0 copayment
D0388	Intraoral tomosynthesis – bitewing image capture	Covered	$0 copayment
D0389	Intraoral tomosynthesis – periapical image capture	One of (D0389) every 12 months per patient	$0 copayment
D0470	Diagnostic casts	One of (D0470) per 12 Month(s) per patient	$0 copayment
Other Diagnostic Services			
D0474	Accession of tissue, gross and microscopic exam (surgical)	Reimbursement is limited to enrolled oral pathologist.	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Other Diagnostic Services			
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	Reimbursement is limited to enrolled oral pathologist.	$0 copayment
D0502	Other oral pathology procedures, by report	Reimbursement is limited to enrolled oral pathologist	$0 copayment
D0999	Unspecified diagnostic procedure, by report	Covered	$0 copayment
Cleanings			
D1110	Prophylaxis – adult	One of (D1110) per 6 Month(s) per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Prophylaxis is intended to control local irritation factors in conjunction with D4341 on the same date of service.	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Fluoride Treatment			
D1206	Topical application of fluoride varnish	One of (D1206, D1208) per 3 Month(s)	$0 copayment
D1208	Topical application of fluoride – excluding varnish	One of (D1206, D1208) per 3 Month(s) per patient. Four of (D1206) per 12 Month(s) per patient	$0 copayment
Other Preventive Dental Services			
D1320	Tobacco counseling for control and prevention of oral disease	Covered	$0 copayment
D1354	Application of caries arresting medicament – per tooth	Covered with topical application of fluoride (D1206 or D1208) when they are performed on the same date of service	$0 copayment
D1999	Unspecified preventive procedure, by report	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2140	Amalgam – one surface, primary or permanent	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) every 12 months	$0 copayment
D2150	Amalgam – two surfaces, primary or permanent	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) every 12 months	$0 copayment
D2160	Amalgam – three surfaces, primary or permanent	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) every 12 months	$0 copayment
D2161	Amalgam – four or more surfaces, primary or permanent	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) every 12 months	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2330	Resin-based composite – one surface, anterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) every 12 months	$0 copayment
D2331	Resin-based composite – two surfaces, anterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) every 12 months	$0 copayment
D2332	Resin-based composite – three surfaces, anterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) every 12 months	$0 copayment
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) every 12 months	$0 copayment
D2390	Resin-based composite crown, anterior	One of (D2390) per 12 month(s) per patient, Same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2391	Resin-based composite – one surface, posterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) every 12 months	$0 copayment
D2392	Resin-based composite – two surfaces, posterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) every 12 months	$0 copayment
D2393	Resin-based composite – three surfaces, posterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) every 12 months	$0 copayment
D2394	Resin-based composite – four or more surfaces, posterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) every 12 months	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2510	Inlay-metallic – 1 surface	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment
D2520	Inlay-metallic – 2 surfaces	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2530	Inlay-metallic – 3+ surfaces	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment
D2542	Onlay-metallic – 2 surfaces	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2620	Inlay-porcelain/ ceramic – 2 surfaces	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment
D2630	Inlay-porc/ceramic – 3+ surfaces	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2710	Crown – resin-based composite (indirect)	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment
D2712	Crown – ¾ resin-based composite (indirect)	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2720	Crown – resin with high noble metal	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment
D2721	Crown – resin with predominantly base metal	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2722	Crown – resin with noble metal	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment
D2740	Crown – porcelain/ ceramic	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2750	Crown – porcelain fused to high noble metal	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment
D2751	Crown – porcelain fused to predominantly base metal	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2752	Crown – porcelain fused to noble metal	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment
D2753	Crown – porcelain fused to titanium and titanium alloys	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2780	Crown – ¾ cast high noble metal	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment
D2781	Crown – ¾ cast predominantly base metal	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2782	Crown – ¾ cast noble metal	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment
D2790	Crown – full cast high noble metal	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2791	Crown – full cast predominantly base metal	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment
D2792	Crown – full cast noble metal	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2794	Crown – titanium	One of (D2510, D2520, D2530, D2542, D2620, D2630, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794), once per tooth per 60 months, per patient	$0 copayment
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	Covered	$0 copayment
D2920	Re-cement or re-bond crown	One of (D2920) per 24 Month(s) per patient, same tooth	$0 copayment
D2931	Prefabricated stainless steel crown-permanent tooth	One of (D2931, D2932, D2933) per 60 Month(s) per patient, same tooth	$0 copayment
D2932	Prefabricated resin crown	One of (D2931, D2932, D2933) per 24 Month(s) per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2933	Prefabricated stainless steel crown with resin window	One of (D2931, D2932, D2933) per 24 Month(s) per patient, same tooth	$0 copayment
D2940	Placement of interim direct restoration	Two every 12 months	$0 copayment
D2951	Pin retention – per tooth, in addition to restoration	Two of (D2951) per 12 Month(s) per patient, same tooth	$0 copayment
D2952	Cast post and core in addition to crown	One of (D2952) per 60 Month(s) per patient, same tooth	$0 copayment
D2953	Each additional cast post – same tooth	One of (D2953) every 60 months per patient, same tooth	$0 copayment
D2954	Prefabricated post and core in addition to crown	One of (D2954) per 60 Month(s) per patient, same tooth	$0 copayment
D2955	Post removal (not in conjunction with endodontic therapy)	One of (D2955) per 60 Month(s), same tooth	$0 copayment
D2980	Crown repair, by report	One of (D2980) per 60 Month(s) per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Restorative Services‡			
D2989	Excavation of a tooth resulting in the determination of a non-restorability	Covered	$0 copayment
D2999	Unspecified restorative procedure, by report	Covered	$0 copayment
Endodontic Services‡			
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	One of (D3220) per 1 Lifetime, same tooth	$0 copayment
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	One of (D3230) per 1 Lifetime per patient, same tooth	$0 copayment
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	One of (D3240) per 1 Lifetime per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Endodontic Services‡			
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	One of (D3310) per 1 Lifetime per patient, same tooth	$0 copayment
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	One of (D3320) per 1 Lifetime per patient, same tooth	$0 copayment
D3330	Endodontic therapy, molar tooth (excluding final restoration)	One of (D3330) per 1 Lifetime per patient, same tooth	$0 copayment
D3346	Retreatment of previous root canal therapy-anterior	One of (D3346) per 1 Lifetime per patient, same tooth	$0 copayment
D3347	Retreatment of previous root canal therapy – premolar	One of (D3347) per 1 Lifetime per patient, same tooth	$0 copayment
D3348	Retreatment of previous root canal therapy – molar	One of (D3348) per 1 Lifetime per patient, same tooth	$0 copayment
D3410	Apicoectomy – anterior	One of (D3410) per 1 Lifetime per patient, same tooth	$0 copayment
D3421	Apicoectomy – premolar (first root)	One of (D3421) per 1 Lifetime per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Endodontic Services‡			
D3425	Apicoectomy – molar (first root)	One of (D3425) per 1 Lifetime per patient, same tooth	$0 copayment
D3426	Apicoectomy (each additional root)	One of (D3426) per 1 Lifetime per patient, same tooth	$0 copayment
D3430	Retrograde filling – per root	One of (D3430) per 1 Lifetime per patient, same tooth	$0 copayment
D3999	Unspecified endodontic procedure, by report	Covered	$0 copayment
Periodontic Services‡			
D4210	Gingivectomy or gingivoplasty – 4 or more contiguous teeth or tooth bounded spaces per quadrant	One of (D4210, D4211) per 12 Month(s), same quadrant	$0 copayment
D4211	Gingivectomy or gingivoplasty – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	One of (D4210, D4211) per 12 Month(s), same quadrant	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Periodontic Services‡			
D4240	Gingival flap procedure, including root planing –4 or more contiguous teeth or tooth bounded spaces per quadrant	One (D4240) every 60 months per patient	$0 copayment
D4245	Apically positioned flap	Covered	$0 copayment
D4249	Clinical crown lengthening – hard tissue	One of (D4249) per 1 Lifetime per patient, same tooth.	$0 copayment
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – 4 or more contiguous teeth or tooth bounded spaces per quadrant	One of (D4260 or D4261), once per quadrant per 60 months, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Periodontic Services‡			
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	One of (D4260 or D4261), once per quadrant per 60 months, per patient	$0 copayment
D4266	Guided tissue regeneration, natural teeth – resorbable barrier, per site	One of (D4266, D4267) per 1 Lifetime per patient, same tooth	$0 copayment
D4267	Guided tissue regeneration, natural teeth –non-resorbable barrier, per site	One of (D4266, D4267) per 1 Lifetime per patient, same tooth	$0 copayment
D4273	Subepithelial connective tissue graft procedure	One of (D4273, D4275) per 1 Lifetime per patient, same tooth	$0 copayment
D4275	Soft tissue allograft	One of (D4273, D4275) per 1 Lifetime per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Periodontic Services‡			
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	One per tooth, per lifetime	$0 copayment
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	One of (D4278) per 1 Lifetime per patient, same tooth	$0 copayment
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	One of (D4283, D4285) per 1 Lifetime per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Periodontic Services‡			
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	One of (D4283, D4285) per 1 Lifetime per patient, same tooth	$0 copayment
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant	One of (D4341, D4342) per 24 Month(s) per patient, same quadrant	$0 copayment
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant	One of (D4341, D4342) per 24 Month(s) per patient, same quadrant	$0 copayment
D4910	Periodontal maintenance procedures	One of (D4910) per 6 Month(s) per patient	$0 copayment
D4999	Unspecified periodontal procedure, by report	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontic Removable Services‡			
D5110	Complete denture – maxillary	One of (D5110, D5211, D5213, D5225) per 96 Month(s) per patient	$0 copayment
D5120	Complete denture – mandibular	One of (D5120, D5212, D5214, D5226) per 96 Month(s) per patient	$0 copayment
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	One of (D5110, D5211, D5213, D5225) per 96 Month(s) per patient	$0 copayment
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	One of (D5120, D5212, D5214, D5226) per 96 Month(s) per patient	$0 copayment
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	One of (D5110, D5211, D5213, D5225) per 96 Month(s) per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontic Removable Services‡			
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	One of (D5120, D5212, D5214, D5226) per 96 Month(s) per patient	$0 copayment
D5225	Maxillary partial denture-flexible base	One of (D5110, D5211, D5213, D5225) per 96 Month(s) per patient	$0 copayment
D5226	Mandibular partial denture-flexible base	One of (D5120, D5212, D5214, D5226) per 96 Month(s) per patient	$0 copayment
D5410	Adjust complete denture-maxillary	4 of (D5410) per 12 Month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5411	Adjust complete denture-mandibular	4 of (D5411) per 12 Month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5421	Adjust partial denture-maxillary	4 of (D5421) per 12 Month(s) per patient. Not covered within 6 months of placement	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontic Removable Services‡			
D5422	Adjust partial denture-mandibular	4 of (D5422) per 12 Month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5511	Repair broken complete denture base, mandibular	Two of (D5511) per 12 Month(s) per patient	$0 copayment
D5512	Repair broken complete denture base, maxillary	Two of (D5512) per 12 Month(s) per patient	$0 copayment
D5520	Replace missing or broken teeth – complete denture – per tooth	One of (D5520) per 12 Month(s) per patient, same tooth	$0 copayment
D5611	Repair resin denture base, mandibular	Two of (D5611) per 12 Month(s) per patient	$0 copayment
D5612	Repair resin denture base, maxillary	Two of (D5612) per 12 Month(s) per patient	$0 copayment
D5621	Repair cast framework, mandibular	One of (D5621) per 12 Month(s) per patient	$0 copayment
D5622	Repair cast framework, maxillary	One of (D5622) per 12 Month(s) per patient	$0 copayment
D5630	Repair or replace broken clasp	Two of (D5630) per 12 Month(s) per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontic Removable Services‡			
D5640	Replace missing or broken teeth – partial denture – per tooth	One of (D5640) per 12 Month(s) per patient, same tooth	$0 copayment
D5650	Add tooth to existing partial denture – per tooth	One of (D5650) per 12 Month(s) per patient, same tooth	$0 copayment
D5660	Add clasp to existing partial denture	One of (D5660) per 12 Month(s) per patient, same tooth	$0 copayment
D5710	Rebase complete maxillary denture	One of (D5710) per 24 Month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5711	Rebase complete mandibular denture	One of (D5711) per 24 Month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5720	Rebase maxillary partial denture	One of (D5720) per 24 Month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5721	Rebase mandibular partial denture	One of (D5721) per 24 Month(s) per patient. Not covered within 6 months of placement	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontic Removable Services‡			
D5725	Rebase of hybrid prosthesis	One of (D5275) every 24 month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5730	Reline complete maxillary denture (chairside)	One of (D5730) per 12 Month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5731	Reline complete mandibular denture (chairside)	One of (D5731) per 12 Month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5740	Reline maxillary partial denture (chairside)	One of (D5740) per 12 Month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5741	Reline mandibular partial denture (chairside)	One of (D5741) per 12 Month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5750	Reline complete maxillary denture (laboratory)	One of (D5750) per 24 Month(s) per patient. Not covered within 6 months of placement	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontic Removable Services‡			
D5751	Reline complete mandibular denture (laboratory)	One of (D5751) per 24 Month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5760	Reline maxillary partial denture (laboratory)	One of (D5760) per 24 Month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5761	Reline mandibular partial denture (laboratory)	One of (D5761) per 24 Month(s) per patient. Not covered within 6 months of placement	$0 copayment
D5820	Interim partial denture – upper	One of (D5820) every 12 month(s) per patient	$0 copayment
D5821	Interim partial denture – lower	One of (D5821) every 12 month(s) per patient	$0 copayment
D5850	Tissue conditioning, maxillary	One of (D5850) per 12 Month(s) per patient	$0 copayment
D5851	Tissue conditioning, mandibular	One of (D5851) per 12 Month(s) per patient	$0 copayment
D5877	Duplication of complete denture – maxillary	One of (D5110, D5130, D5877) per 60 months, per patient	$0 copayment
D5878	Duplication of complete denture – mandibular	One of (D5120, D5140, D5878) per 60 months, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontic Removable Services‡			
D5899	Unspecified removable prosthodontic procedure, by report	Covered	$0 copayment
Maxillofacial Prosthetics‡			
D5909	Maxillary guidance prosthesis with guide flange	Covered	$0 copayment
D5911	Facial moulage (sectional)	One of (D5911) per 12 Month(s) per patient	$0 copayment
D5912	Facial moulage (complete)	One of (D5912) per 12 Month(s) per patient	$0 copayment
D5913	Nasal prosthesis	One of (D5913) per 12 Month(s) per patient	$0 copayment
D5914	Auricular prosthesis	One of (D5914) per 12 Month(s) per patient	$0 copayment
D5915	Orbital prosthesis	One of (D5915) per 12 Month(s) per patient	$0 copayment
D5916	Ocular prosthesis	One of (D5916) per 12 Month(s) per patient	$0 copayment
D5919	Facial prosthesis	6 of (D5919) per 2 Month(s) per patient	$0 copayment
D5922	Nasal septal prosthesis	One of (D5922) per 12 Month(s) per patient	$0 copayment
D5923	Ocular prosthesis, interim	One of (D5923) per 12 Month(s) per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Maxillofacial Prosthetics‡			
D5924	Cranial prosthesis	One of (D5924) per 12 Month(s) per patient	$0 copayment
D5925	Facial augment implant prosthesis	One of (D5925) per 12 Month(s) per patient	$0 copayment
D5926	Nasal prosthesis, replacement	One of (D5926) per 12 Month(s) per patient	$0 copayment
D5927	Auricular prosthesis, replace	One of (D5927) per 12 Month(s) per patient	$0 copayment
D5928	Orbital prosthesis, replace	One of (D5928) per 12 Month(s) per patient	$0 copayment
D5929	Facial prosthesis, replacement	One of (D5929) per 12 Month(s) per patient	$0 copayment
D5930	Maxillary guidance prosthesis without guide flange	Covered	$0 copayment
D5931	Obturator prosthesis, surgical	One of (D5931) per 12 Month(s) per patient	$0 copayment
D5932	Obturator prosthesis, definitive	One of (D5932) per 12 Month(s) per patient	$0 copayment
D5933	Obturator prosthesis, modification	One of (D5933) per 6 Month(s) per patient	$0 copayment
D5934	Mandibular resection prosthesis with guide flange	One of (D5934) per 12 Month(s) per patient	$0 copayment
D5935	Mandibular resection prosthesis without guide flange	One of (D5935) per 12 Month(s) per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Maxillofacial Prosthetics‡			
D5936	Obturator prosthesis, interim	One of (D5936) per 12 Month(s) per patient	$0 copayment
D5937	Trismus appliance (not for TMD treatment)	One of (D5937) per 12 Month(s) per patient	$0 copayment
D5938	Resection prosthesis, maxillary complete removable	Covered	$0 copayment
D5939	Resection prosthesis, mandibular complete removable	Covered	$0 copayment
D5940	Resection prosthesis, maxillary partial removable	Covered	$0 copayment
D5941	Resection prosthesis, mandibular partial removable	Covered	$0 copayment
D5942	Resection prosthesis, maxillary implant/ abutment supported removable prosthesis for edentulous arch	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Maxillofacial Prosthetics‡			
D5943	Resection prosthesis, mandibular implant/ abutment supported removable prosthesis for edentulous arch	Covered	$0 copayment
D5944	Resection prosthesis, maxillary implant/ abutment supported removable prosthesis for the partial edentulous arch	Covered	$0 copayment
D5945	Resection prosthesis, mandibular implant/ abutment supported removable prosthesis for the partial edentulous arch	Covered	$0 copayment
D5946	Resection prosthesis, maxillary implant/ abutment supported fixed prosthesis for edentulous arch	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Maxillofacial Prosthetics‡			
D5947	Resection prosthesis, mandibular implant/ abutment supported fixed prosthesis for edentulous arch	Covered	$0 copayment
D5948	Resection prosthesis, maxillary implant/ abutment supported fixed prosthesis for the partial edentulous arch	Covered	$0 copayment
D5949	Resection prosthesis, mandibular implant/ abutment supported fixed prosthesis for the partial edentulous arch	Covered	$0 copayment
D5951	Feeding aid	One of (D5951) per 12 Month(s) per patient	$0 copayment
D5953	Speech aid prosthesis, adult	One of (D5953) per 12 Month(s) per patient	$0 copayment
D5954	Palatal augment prosthesis	One of (D5954) per 12 Month(s) per patient	$0 copayment
D5955	Palatal lift prosthesis, definitive	One of (D5955) per 12 Month(s) per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Maxillofacial Prosthetics‡			
D5958	Palatal lift prosthesis, interim	One of (D5958) per 12 Month(s) per patient	$0 copayment
D5959	Palatal lift prosthesis, modification	One of (D5959) per 12 Month(s) per patient	$0 copayment
D5960	Speech aid prosthesis, modification	One of (D5960) per 12 Month(s) per patient	$0 copayment
D5982	Surgical stent	One of (D5982) per 12 Month(s) per patient	$0 copayment
D5983	Radiation carrier	One of (D5983) per 12 Month(s) per patient	$0 copayment
D5984	Radiation shield	One of (D5984) per 12 Month(s) per patient	$0 copayment
D5985	Radiation cone locator	One of (D5985) per 12 Month(s) per patient	$0 copayment
D5986	Fluoride gel carrier	Two of (D5986) per 12 Month(s) per patient, same arch	$0 copayment
D5987	Commissure splint	One of (D5987) per 12 Month(s) per patient	$0 copayment
D5988	Surgical splint	One of (D5988) per 12 Month(s) per patient	$0 copayment
D5999	Unspecified maxillofacial prosthesis, by report	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Implants Services‡			
D6010	Surgical placement of implant body: endosteal implant	One of (D6010, D6013) per 1 Lifetime per patient, same tooth	$0 copayment
D6013	Surgical placement of mini implant	One of (D6010, D6013) per 1 Lifetime per patient, same tooth	$0 copayment
D6049	Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	Covered	$0 copayment
D6055	Connecting bar – implant supported or abutment supported	One of (D6055) per 8 years, per patient, same arch	$0 copayment
D6056	Prefabricated abutment – includes modification and placement	One of (D6056, D6057) per 8 years per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Implants Services‡			
D6057	Custom fabricated abutment – includes placement	One of (D6056, D6057) per 8 years per patient, same tooth	$0 copayment
D6058	Abutment supported porcelain/ceramic crown	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 8 years per patient, same tooth	$0 copayment
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 8 years per patient, same tooth	$0 copayment
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 8 years per patient, same tooth	$0 copayment
D6061	Abutment supported porcelain fused to metal crown (noble metal)	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 8 years per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Implants Services‡			
D6062	Abutment supported cast metal crown (high noble metal)	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 8 years per patient, same tooth	$0 copayment
D6063	Abutment supported cast metal crown (predominantly base metal)	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 8 years per patient, same tooth	$0 copayment
D6064	Abutment supported cast metal crown (noble metal)	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 8 years per patient, same tooth	$0 copayment
D6065	Implant supported porcelain/ceramic crown	One of (D6065, D6066, D6067) per 8 years per patient, same tooth	$0 copayment
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	One of (D6065, D6066, D6067) per 8 years per patient, same tooth	$0 copayment
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	One of (D6065, D6066, D6067) per 8 years per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Implants Services‡			
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	One of (D6081) per 12 Month(s) per patient, same tooth	$0 copayment
D6090	Repair of implant/ abutment supported prosthesis	One of (D6090) per 12 Month(s) per patient	$0 copayment
D6091	Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/ abutment supported prosthesis, per attachment	One of (D6091) per 12 Month(s) per patient, same quadrant	$0 copayment
D6092	Re-cement or re-bond implant/abutment supported crown	One of (D6092) per 2 years per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Implants Services‡			
D6093	Re-cement or re-bond implant/ abutment supported fixed partial denture	One of (D6093) per 2 years per patient, same tooth	$0 copayment
D6094	Abutment supported crown – (titanium)	One of (D6094) per 8 Year(s) per patient, same tooth	$0 copayment
D6095	Repair implant abutment	One of (D6095) per 12 Month(s) per patient, same tooth	$0 copayment
D6096	Remove broken implant retaining screw	One of (D6096) per 12 Month(s) per patient, same tooth	$0 copayment
D6100	Surgical removal of implant body	Covered	$0 copayment
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	One of (D6101, D6102) per 2 Year(s) per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Implants Services‡			
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	One of (D6101, D6102) per 2 Year(s) per patient, same tooth	$0 copayment
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately	One of (D6103) per 2 Year(s) per patient, same tooth	$0 copayment
D6104	Bone graft at time of implant placement	One of (D6104) per 1 Lifetime per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Implants Services‡			
D6106	Guided tissue regeneration – resorbable barrier, per implant	Covered	$0 copayment
D6107	Guided tissue regeneration – non-resorbable barrier, per implant	Covered	$0 copayment
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary	One of (D6110, D6112) per 8 years per patient, same arch	$0 copayment
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular	One of (D6111, D6113) per 8 years per patient, same arch	$0 copayment
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary	One of (D6110, D6112) per 8 years per patient, same arch	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Implants Services‡			
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular	One of (D6111, D6113) per 8 years per patient, same arch	$0 copayment
D6190	Radiographic/ surgical implant index, by report	One of (D6190) per 12 Month(s) per patient, same arch	$0 copayment
D6191	Semi-precision abutment – placement	One of (D6191) per 8 years per patient, same tooth	$0 copayment
D6192	Semi-precision attachment – placement	One of (D6192) per 8 years per patient, same tooth	$0 copayment
D6193	Replacement of an implant screw	One of (D6193) per 12 Month(s) per patient per tooth	$0 copayment
D6199	Unspecified implant procedure	Covered	$0 copayment
Prosthodontics Fixed Services‡			
D6210	Pontic – cast high noble metal	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontics Fixed Services‡			
D6211	Pontic – cast base metal	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) per patient, same tooth	$0 copayment
D6212	Pontic – cast noble metal	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) per patient, same tooth	$0 copayment
D6214	Pontic – titanium	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) per patient, same tooth	$0 copayment
D6240	Pontic – porcelain fused – high noble	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontics Fixed Services‡			
D6241	Pontic – porcelain fused to base metal	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) per patient, same tooth	$0 copayment
D6242	Pontic – porcelain fused – noble metal	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) per patient, same tooth.	$0 copayment
D6243	Pontic – porcelain fused to titanium and titanium alloys	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s)	$0 copayment
D6245	Prosthodontics fixed, pontic – porcelain/ceramic	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontics Fixed Services‡			
D6250	Pontic – resin with high noble metal	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) per patient, same tooth	$0 copayment
D6251	Pontic – resin with base metal	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) per patient, same tooth	$0 copayment
D6252	Pontic – resin with noble metal	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) per patient, same tooth	$0 copayment
D6545	Retainer – cast metal fixed	One of (D6545) per 60 Month(s) per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontics Fixed Services‡			
D6720	Crown – resin with high noble metal	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment
D6721	Crown – resin with base metal	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth.	$0 copayment
D6722	Crown – resin with noble metal	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontics Fixed Services‡			
D6740	Retainer crown – porcelain/ ceramic	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment
D6750	Crown – porcelain fused high noble	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment
D6751	Crown – porcelain fused to base metal	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontics Fixed Services‡			
D6752	Crown – porcelain fused noble metal	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment
D6780	Crown – ¾ cast high noble metal	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontics Fixed Services‡			
D6781	Prosthodontics fixed, crown ¾ cast predominantly based metal	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment
D6782	Prosthodontics fixed, crown ¾ cast noble metal	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment
D6783	Prosthodontics fixed, crown ¾ porcelain/ceramic	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontics Fixed Services‡			
D6784	Retainer crown –¾-titanium and titanium alloys	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment
D6790	Crown – full cast high noble	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment
D6791	Crown – full cast base metal	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Prosthodontics Fixed Services‡			
D6792	Crown – full cast noble metal	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment
D6794	Crown – titanium	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) per patient, same tooth	$0 copayment
D6930	Re-cement or re-bond fixed partial denture	One of (D6930) per 24 Month(s) per patient, same quadrant	$0 copayment
D6980	Fixed partial denture repair	One of (D6980) per 60 Month(s) per patient, same quadrant	$0 copayment
D6999	Fixed prosthodontic procedure	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7111	Extraction, coronal remnants – primary tooth	One of (D7111) per 1 Lifetime per patient, same tooth	$0 copayment
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	One of (D7140) per 1 Lifetime per patient, same tooth	$0 copayment
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	One of (D7210) per 1 Lifetime per patient, same tooth	$0 copayment
D7220	Removal of impacted tooth-soft tissue	One of (D7220) per 1 Lifetime per patient, same tooth	$0 copayment
D7230	Removal of impacted tooth-partially bony	One of (D7230) per 1 Lifetime per patient, same tooth	$0 copayment
D7240	Removal of impacted tooth-completely bony	One of (D7240) per 1 Lifetime per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	One of (D7210) per 1 Lifetime per patient, same tooth	$0 copayment
D7220	Removal of impacted tooth-soft tissue	One of (D7220) per 1 Lifetime per patient, same tooth	$0 copayment
D7230	Removal of impacted tooth-partially bony	One of (D7230) per 1 Lifetime per patient, same tooth	$0 copayment
D7240	Removal of impacted tooth-completely bony	One of (D7240) per 1 Lifetime per patient, same tooth	$0 copayment
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	One of (D7241) per 1 Lifetime per patient, same tooth	$0 copayment
D7250	Surgical removal of residual tooth roots (cutting procedure)	One of (D7250) per 1 Lifetime per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7260	Oroantral fistula closure	One of (D7260) per 1 Lifetime per patient, same quadrant	$0 copayment
D7261	Primary closure of a sinus perforation	One of (D7261) per 1 Lifetime per patient, same quadrant	$0 copayment
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	One of (D7270) per 1 Lifetime per patient, same tooth	$0 copayment
D7272	Tooth transplantation (includes reimplantation from one site to another)	One of (D7272) per 1 Lifetime per patient, same tooth	$0 copayment
D7280	Surgical access of an unerupted tooth	One of (D7280) per 1 Lifetime per patient, same tooth	$0 copayment
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	One of (D7282) per 1 Lifetime per patient, same tooth	$0 copayment
D7283	Placement of device to facilitate eruption of impacted tooth	One of (D7283) per 1 Lifetime per patient, same tooth	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	One of (D7285) per 12 Month(s) per patient	$0 copayment
D7286	Incisional biopsy of oral tissue-soft	One of (D7286) per 12 Month(s) per patient, same quadrant	$0 copayment
D7290	Surgical repositioning of teeth	One of (D7290) per 1 Lifetime per patient, same tooth	$0 copayment
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	One of (D7310, D7311, D7320, D7321) per 1 Lifetime per patient, same quadrant	$0 copayment
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	One of (D7310, D7311, D7320, D7321) per 1 Lifetime per patient, same quadrant	$0 copayment
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	One of (D7310, D7311, D7320, D7321) per 1 Lifetime per patient, same quadrant	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	One of (D7310, D7311, D7320, D7321) per 1 Lifetime per patient, same quadrant	$0 copayment
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	Two of (D7340) per 60 Month(s) per patient, same arch	$0 copayment
D7350	Vestibuloplasty – ridge extension	Two of (D7350) per 60 Month(s) per patient, same arch	$0 copayment
D7410	Radical excision – lesion diameter up to 1.25cm	Covered	$0 copayment
D7411	Excision of benign lesion greater than 1.25 cm	Covered	$0 copayment
D7412	Excision of benign lesion, complicated	Covered	$0 copayment
D7413	Excision of malignant lesion up to 1.25 cm	Covered	$0 copayment
D7414	Excision of malignant lesion greater than 1.25 cm	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7415	Excision of malignant lesion, complicated	Covered	$0 copayment
D7440	Excision of malignant tumor – lesion diameter up to 1.25cm	Covered	$0 copayment
D7441	Excision of malignant tumor – lesion diameter greater than 1.25cm	Covered	$0 copayment
D7450	Removal of odontogenic cyst or tumor – lesion diameter up to 1.25cm	Covered	$0 copayment
D7451	Removal of odontogenic cyst or tumor – lesion greater than 1.25cm	Covered	$0 copayment
D7460	Removal of nonodontogenic cyst or tumor – lesion diameter up to 1.25cm	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7461	Removal of nonodontogenic cyst or tumor – lesion greater than 1.25cm	Covered	$0 copayment
D7465	Destruction of lesion(s) by physical or chemical method, by report	Covered	$0 copayment
D7471	Removal of exostosis – per site	One per tooth, per lifetime	$0 copayment
D7472	Removal of torus palatinus	Covered	$0 copayment
D7473	Removal of torus mandibularis	Covered	$0 copayment
D7485	Surgical reduction of osseous tuberosity	One of (D7485) per 1 Lifetime per patient, same quadrant	$0 copayment
D7490	Radical resection of maxilla or mandible	Covered	$0 copayment
D7510	Incision and drainage of abscess – intraoral soft tissue	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	Covered	$0 copayment
D7520	Incision and drainage of abscess – extraoral soft tissue	Covered	$0 copayment
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	Covered	$0 copayment
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	Covered	$0 copayment
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7550	Partial ostectomy/ sequestrectomy for removal of non-vital bone	Covered	$0 copayment
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	Covered	$0 copayment
D7610	Maxilla – open reduction	Covered	$0 copayment
D7620	Maxilla – closed reduction	Covered	$0 copayment
D7630	Mandible – open reduction	Covered	$0 copayment
D7640	Mandible – closed reduction	Covered	$0 copayment
D7650	Malar and/or zygomatic arch- open reduction	Covered	$0 copayment
D7660	Malar and/or zygomatic arch- closed	Covered	$0 copayment
D7670	Alveolus stabilization of teeth, closed reduction splinting	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7671	Alveolus – open reduction, may include stabilization of teeth	Covered	$0 copayment
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	Covered	$0 copayment
D7710	Maxilla – open reduction	Covered	$0 copayment
D7720	Maxilla – closed reduction	Covered	$0 copayment
D7730	Mandible – open reduction	Covered	$0 copayment
D7740	Mandible – closed reduction	Covered	$0 copayment
D7750	Malar and/or zygomatic arch-open reduction	Covered	$0 copayment
D7760	Malar and/or zygomatic arch-closed reduction	Covered	$0 copayment
D7770	Alveolus-stabilization of teeth, open reduction splinting	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7771	Alveolus, closed reduction stabilization of teeth	Covered	$0 copayment
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	Covered	$0 copayment
D7810	Open reduction of dislocation	Covered	$0 copayment
D7820	Closed reduction dislocation	Covered	$0 copayment
D7830	Manipulation under anesthesia	Covered	$0 copayment
D7840	Condylectomy	Covered	$0 copayment
D7850	Surgical discectomy, with/without implant	Two of (D7850) per 1 Lifetime per patient	$0 copayment
D7852	Disc repair	Two of (D7852) per 1 Lifetime per patient	$0 copayment
D7854	Synovectomy	Two of (D7854) per 1 Lifetime per patient	$0 copayment
D7856	Myotomy	Two of (D7856) per 1 Lifetime per patient	$0 copayment
D7858	Joint reconstruction	Two of (D7858) per 1 Lifetime per patient	$0 copayment
D7860	Arthrotomy	Two of (D7860) per 1 Lifetime per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7865	Arthroplasty	Two of (D7865) per 1 Lifetime per patient	$0 copayment
D7870	Arthrocentesis	One of (D7870) per 6 Month(s) per patient	$0 copayment
D7872	Arthroscopy – diagnosis with or without biopsy	Two of (D7872) per 1 Lifetime per patient	$0 copayment
D7873	Arthroscopy-surgical: lavage and lysis of adhesions	Two of (D7873) per 1 Lifetime per patient	$0 copayment
D7874	Arthroscopy-surgical: disc repositioning and stabilization	Two of (D7874) per 1 Lifetime per patient	$0 copayment
D7875	Arthroscopy-surgical synovectomy	Two of (D7875) per 1 Lifetime per patient	$0 copayment
D7876	Arthroscopy-surgery discectomy	Two of (D7876) per 1 Lifetime per patient	$0 copayment
D7877	Arthroscopy-surgical debridement	Two of (D7877) per 1 Lifetime per patient	$0 copayment
D7880	Occlusal orthotic device, by report	One of (D7880) per 12 Month(s) per patient	$0 copayment
D7899	Unspecified tmd therapy, by report	Covered	$0 copayment
D7910	Suture small wounds up to 5 cm	Covered	$0 copayment
D7911	Complicated suture-up to 5 cm	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7912	Complex suture – greater than 5cm	Covered	$0 copayment
D7920	Skin graft (identify defect covered, location and type of graft)	Covered	$0 copayment
D7940	Osteoplasty – for orthognathic deformities	Covered	$0 copayment
D7941	Osteotomy – mandibular rami	Covered	$0 copayment
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	Covered	$0 copayment
D7944	Osteotomy – segmented or subapical – per sextant or quadrant	Covered	$0 copayment
D7945	Osteotomy – body of mandible	Covered	$0 copayment
D7946	Lefort i (maxilla – total)	Covered	$0 copayment
D7947	Lefort i (maxilla – segmented)	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7948	Lefort ii or lefort iii – without bone graft	Covered	$0 copayment
D7949	Lefort ii or lefort iii – with bone graft	Covered	$0 copayment
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	Covered	$0 copayment
D7951	Sinus augmentation	One of (D7951) per 1 Lifetime per patient, same quadrant	$0 copayment
D7952	Sinus augmentation via a vertical approach	Covered	$0 copayment
D7953	Bone replacement graft for ridge preservation – per site	One of (D7953) per 1 Lifetime per patient, same tooth	$0 copayment
D7961	Buccal / labial frenectomy (frenulectomy)	Three of (D7961) per 1 Lifetime per patient, same arch	$0 copayment
D7962	Lingual frenectomy (frenulectomy)	Three of (D7962) per 1 Lifetime per patient, same arch	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Oral and Maxillofacial Surgery Services‡			
D7970	Excision of hyperplastic tissue – per arch	Two of (D7970) per 1 Lifetime per patient, same arch	$0 copayment
D7971	Excision of pericoronal gingiva	One of (D7971) per 24 Month(s) per patient, same tooth	$0 copayment
D7972	Surgical reduction of fibrous tuberosity	Two of (D7972) per 1 Lifetime per patient, same quadrant	$0 copayment
D7980	Surgical sialolithotomy	Covered	$0 copayment
D7981	Excision of salivary gland, by report	Covered	$0 copayment
D7982	Sialodochoplasty	Covered	$0 copayment
D7993	Closure of salivary fistula	Covered	$0 copayment
D7990	Emergency tracheotomy	Covered	$0 copayment
D7991	Coronoidectomy	One of (D7991) per 1 Lifetime per patient	$0 copayment
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Adjunctive General Services‡			
D7998	Intraoral fixation device – non-fracture	Covered	$0 copayment
D7999	Unspecified oral surgery procedure, by report	Covered	$0 copayment
D9110	Palliative treatment of dental pain – per visit	Two of (D9110) per 12 Month(s) per patient	$0 copayment
D9120	Fixed partial denture sectioning	Covered	$0 copayment
D9210	Local anesthesia not in conjunction with operative or surgical procedure *not billable separately from main service	Covered	$0 copayment
D9211	Regional block anesthesia *not billable separately from main service	Covered	$0 copayment
D9212	Trigeminal division block anesthesia *not billable separately from main service	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Adjunctive General Services‡			
D9215	Local anesthesia *not billable separately from main service	Covered	$0 copayment
D9219	Anesthesia	Covered	$0 copayment
D9222	Deep sedation/ general anesthesia- first 15 minutes	Covered	$0 copayment
D9223	Deep sedation/ general anesthesia – each subsequent 15 minute increment	Covered	$0 copayment
D9224	Administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof	One of (D9222, D9224, D9239) per date of service, per patient	$0 copayment
D9225	Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	3 of (D9223, D9225, D9243) per date of service, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Adjunctive General Services‡			
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	Not allowed on same day as D9222, D9223, D9239, D9243, or D9248.	$0 copayment
D9239	Intravenous moderation (conscious)	Covered	$0 copayment
D9243	Intravenous moderation (conscious)– each subsequent 15 minute increment	Covered	$0 copayment
D9244	In-office administration of minimal sedation – single drug – enteral	One of (D9244, D9245, D9246, D9247) per date of service, per patient	$0 copayment
D9245	Administration of moderate sedation – enteral	One of (D9244, D9245, D9246, D9247) per date of service, per patient	$0 copayment
D9246	Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof	One of (D9244, D9245, D9246, D9247) per date of service, per patient	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Adjunctive General Services‡			
D9247	Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute in-crement, or any portion thereof	One of (D9244, D9245, D9246, D9247) per date of service, per patient	$0 copayment
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	One of (D9310) per 6 Month(s) per patient	$0 copayment
D9311	Consultation with a medical health care professional	One of (D9311) per 7 day(s)	$0 copayment
D9410	House/extended care facility call	Covered	$0 copayment
D9420	Hospital or ambulatory surgical center call	Professional visits for pre-operative or operative care	$0 copayment
D9430	Office visit for observation – no other services performed	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Adjunctive General Services‡			
D9440	Office visit – after regularly scheduled hours	Covered	$0 copayment
D9610	Therapeutic drug injection, by report	Covered	$0 copayment
D9612	Therapeutic drug injection – 2 or more medications by report	Covered	$0 copayment
D9910	Application of desensitizing medicament	Covered	$0 copayment
D9936	Cleaning and inspection of occlusal guard – per appliance	One of (D9936) per 12 months	$0 copayment
D9944	Occlusal guard – hard appliance, full arch	One of (D9944, D9945, D9946) per 12 Month(s) per patient	$0 copayment
D9945	Occlusal guard – soft appliance full arch	One of (D9944, D9945, D9946) per 12 Month(s) per patient	$0 copayment
D9946	Occlusal guard – hard appliance, partial arch	One of (D9944, D9945, D9946) per 12 Month(s) per patient	$0 copayment
D9951	Occlusal adjustment – limited	Covered	$0 copayment

Code	Procedure Name	Frequency Limitations	Copayment
Adjunctive General Services‡			
D9952	Occlusal adjustment – complete	Covered	$0 copayment
D9990	Certified translation or sign-language services per visit	Covered	$0 copayment
D9991	Dental case management – addressing appointment compliance barriers	Covered	$0 copayment
D9995	Teledentistry – synchronous; real-time encounter	Covered	$0 copayment
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	Covered	$0 copayment
D9997	Dental case management – patients with special health care needs	One every 6 months	$0 copayment
D9999	Unspecified adjunctive procedure, by report	Covered	$0 copayment

‡ Authorization may be required for Supplemental Comprehensive Dental Services

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 2026 the amounts for each benefit period are $0* or: $1,736 deductible. Days 1–60: $0 copayment per day. Days 61–90: $434 copayment per day. Days 91 and beyond: $868 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.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Mental Health Care *(continued)*	Inpatient Mental Health *(continued)*	These are 2026 cost-sharing amounts and may change for 2027. Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) will provide updated rates at www.elderplan.org as soon as they are released.	

*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	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 2026* the amounts for each benefit period: Days 1–20: $0 per day. Days 21–100: $217 copayment per day. Days 101 and beyond: you pay all costs. These are 2026 cost-sharing amounts and may change for 2027. Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP) will provide updated rates at www.elderplan.org as soon as they are released.	The plan covers up to 100 days each benefit period, a 3-day prior hospital stay is required. Authorization is required.

*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 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.
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.

*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 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.	Some Medicare Part B Prescription Drugs may be subject to step therapy requirements. 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 $37.90 per month.
Part D Deductible	Most Elderplan for Medicaid Beneficiaries members get "Extra Help" with their prescription drug costs. For 2027, the Part D deductible is $700. 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.

Medicare Part D

Initial Coverage Stage: One-Month Supply (30-Days) and Extended Supply (up to 90-Days) *^†Ω

If you <u>do</u> qualify for or get "Extra Help" with the cost of your Medicare Part D prescription drugs

	100% Extra Help - Part D Premium Subsidy	Your Level of Extra Help - LIS 1 Copayments	Your Level of Extra Help - LIS 2 Copayments
Tier 1: All Drugs	$0	Deductible $0	Deductible $0
		Generic $5.80	Generic $1.65
		Brand $14.40	Brand $5.00

If you <u>do not</u> qualify for "Extra Help" with the cost of your Medicare Part D prescription drugs

	Part D Premium	Deductible	Initial Coverage Stage: One-Month Supply (30-days) and Extended Supply (up to 90-days) *^† Ω	Catastrophic Coverage
Tier 1: All Drugs	$37.90 per month	$700	Generic 25% of the cost	$0 After you meet your Out-of-pocket Threshold $2,400
			Brand 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 $2,400, you will move to the next stage (the Catastrophic stage).

Medicare Part D

Catastrophic Coverage Stage

Once your "out-of-pocket costs" reach a total of $2,400, 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.
	Diabetic Monitors	$0 copayment for Continuous Glucose Monitors and supplies are available at participating pharmacies. All other devices are 20%.	Continuous Glucose Monitors are limited to specific manufacturers: Freestyle Libre. Authorization may be required.

Other Covered Services			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Medical Equipment and Supplies *(continued)*	Durable Medical Equipment (like wheelchairs or oxygen)	0% or 20% coinsurance for Medicare-covered Durable Medical Equipment (DME).*	Authorization is required for certain items.
	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.

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

Other Covered Services			
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 $375 allowance to use in 2027 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 2027 or if you disenroll from the plan.

More benefits with your plan	
OTC	You may purchase up to $200 every month of eligible OTC items on an OTC card provided by Elderplan.
Expanded OTC (SSBCI)	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, Home delivered meals, Personal Hygiene, Pest Control, and Indoor Air Quality Equipment and Services 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. Authorization is only required for in-home visits. **Out-of-Network:** $0 copayment per visit. You may receive up to 12 Routine Foot Care visits per year. Authorization is only required for in-home visits.

More benefits with your plan

Silver&Fit® Fitness Program	Members have access to the Silver&Fit® Healthy Aging and Exercise program at no cost. Under this program, members can access no-cost participating fitness centers. In addition, members can choose 1 (one) home fitness kit per benefit year at no cost. Members can also access other Silver&Fit program features including thousands of on-demand workout videos, virtual events through the Well-Being club, and specialized coaching sessions. 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 mobile device 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. There is no coinsurance or copayment for Worldwide Emergency Travel Assistance services arranged by our worldwide emergency travel assistance provider.

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 Putnam County (845) 808-1500 Monday through Friday 9 AM to 5 PM 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 Putnam County DSS 110 Old Route Six, Carmel, New York 10512-2110 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, state, and local civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Elderplan/HomeFirst does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes.

In compliance with Section 1557 and other federal civil rights laws, we provide individuals the following in a timely manner and free of charge:

- Language assistance services. Elderplan/HomeFirst will provide language assistance services for individuals with limited English proficiency (including individuals' companions with limited English proficiency) to ensure meaningful access to our programs, activities, services, and other benefits. Language assistance services may include:
    - Electronic and written translated documents
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Appropriate auxiliary aids and services. Elderplan/HomeFirst will provide appropriate auxiliary aids and services for individuals with disabilities (including individuals' companions with disabilities) to ensure effective communication. Appropriate auxiliary aids and services may include:
    - Qualified interpreters, including American Sign Language interpreters
    - Video remote interpreting
    - Information in alternate formats (including but not limited to large print, braille, recorded audio, and accessible electronic formats)
    - Qualified readers

- Reasonable modifications. Elderplan/HomeFirst will provide reasonable modifications for qualified individuals with disabilities, when necessary to ensure accessibility and equal opportunity to participate in our programs, activities, services, or other benefits.

To access our language assistance services, auxiliary aids and services, and for assistance in getting a reasonable modification, please call 1-800-353-3765 (TTY:711).

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 by mail, phone, or fax to:

Elderplan, Inc.
ATTN Civil Rights Coordinator
55 Water Street, 46th Floor
New York, NY 10041

Phone: 1-877-326-9978, TTY 711
Fax: 1-718-759-3643

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/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F
Washington, D.C. 20201

1-800-368-1019, TDD: 1-800-537-7697

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services
45 CFR 92.11

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

تمتثل Elderplan Inc. لقوانين الحقوق المدنية الفيدرالية المعمول بها ولا تميّز على أساس العِرق أو اللون أو الأصل 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 مجانًا. 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 auxiliaires 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 Sprachassistenzdienste 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 nasyonal, 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 ਬਿਨ੍ਹਾਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ ਜਾਂ ਵਿਆਖਿਆ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੁੰਦੀ ਹੈ, ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ 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 nandidiskrimina 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 serbisyong 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. פֿאָלגט די אָנוועונדלעכע פּעדעראלע ציווילע רעכט געזעצן און דיסקרימינירט נישט אויף דער באַזע פון ראַסע, קאָליר, נאַציאָנאַלער אָפּשטאַם, עלטער, דיסאַביליטי, אָדער געשלעכט. ופמערקזאַמקייַט: אויב איר רעדט אַ נישט-ענגלישע שפּראַך אָדער דאַרפֿט הילף מיט איבערזעצונג, זענען שפּראַך הילף באַדינונגען און פּאַסיק הילפסמיטלען בנימצא פֿאַר אײַך אָן קיין אָפּצאָל. אויב איר דאַרפט די סערוויסעס אדער האָט פֿראַגעס וועגן אונדזער פּלאַן, רופֿט אָן 1-800-353-3765 (TTY: 711)

Pre-Enrollment Checklist

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

Understanding the Benefits

- ☐ 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, 2028**.
- ☐ 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 participating agency 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.