

2024



CENTERS PLAN  
FOR HEALTHY  
LIVING



# Summary of Benefits

Centers Plan for Dual Coverage  
Care (HMO D-SNP)





# 2024 Summary of Benefits

Centers Plan for Dual Coverage Care (HMO D-SNP)

January 1, 2024 - December 31, 2024

H6988, Plan 002

Our service area includes the following counties in New York State:



Hudson Valley

Rockland  
County

Long Island

Nassau  
County

New York City

Bronx, Kings (Brooklyn),  
New York (Manhattan),  
Queens, and Richmond  
(Staten Island) Counties



**Member Services** can be reached via:

PHONE

1-877-940-9330  
(TTY users, please call 711)  
Seven days a week,  
from 8 am to 8 pm

WEBSITE

[www.centersplan.com/dsnp](http://www.centersplan.com/dsnp)

EMAIL

[MemberServices@centersplan.com](mailto:MemberServices@centersplan.com)

MAIL

Centers Plan for Healthy Living  
75 Vanderbilt Avenue, 7<sup>th</sup> Floor  
Staten Island, NY 10304

## 2024 SUMMARY OF BENEFITS – Centers Plan for Dual Coverage Care (HMO D-SNP)

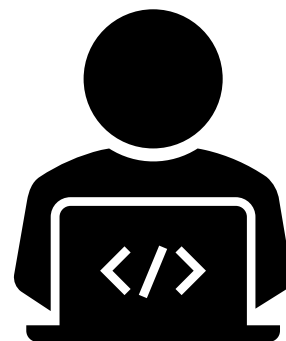
---

Please contact Member Services if you would like this information in large print, braille, or Spanish.

Member Services also has free language interpretation services available for people who do not speak English.

Comuníquese con Servicios para miembros si desea esta información en letra grande, braille o español.

Servicios para miembros también tiene servicios gratuitos de interpretación de idiomas disponibles para personas que no hablan inglés.



H6988-002\_CY24SB\_M

## DISCLAIMERS



When this booklet says “we,” “us,” or “our,” it means Centers Plan for Healthy Living, LLC. When it says “plan” or “our plan,” it means **Centers Plan for Dual Coverage Care**.



**Centers Plan for Dual Coverage Care (HMO D-SNP)** is an HMO with Medicare and Medicaid contracts. Enrollment in Centers Plan for Dual Coverage Care depends on contract renewal. The plan also has a written agreement with the New York State Medicaid program to coordinate your Medicaid benefits.



This is a summary of health services covered by our plan. The benefit information provided does not list every service that we cover, limitation, or exclusion. To get a complete list of covered services, please call Member Services at 1-877-940-9330 (TTY users, please call 711) to request the *Evidence of Coverage*, or access it online at [www.centersplan.com/dsnp](http://www.centersplan.com/dsnp).



Centers Plan for Dual Coverage Care has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. You can see our plan’s *Provider/Pharmacy Directories* and *Evidence of Coverage* at [www.centersplan.com/dsnp](http://www.centersplan.com/dsnp). Or call us and we will send you a copy of the directory.

## DISCLAIMERS

Except in emergency situations, if you use providers that are not in our network, we may not pay for the services you receive.



Generally, you must use network pharmacies to fill your prescriptions for covered Part D drugs. You may need a referral and/or authorization to get some types of care.

Our plan's provider and pharmacy directories are available on our website at [www.centersplan.com/dsnp](http://www.centersplan.com/dsnp). Please contact us to request paper copies of the directories.



For coverage and costs of Original Medicare, look in your current **“Medicare & You”** handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), seven days a week, 24 hours a day. TTY users, please call 1-877-486-2048.



## **ELIGIBILITY**

**Centers Plan for Dual Coverage Care** is a Medicare Advantage “Special Needs Plan” or “SNP,” which means its benefits, providers, and drug formularies (i.e., list of covered drugs) are tailored to best meet the needs of people with specific medical conditions or characteristics.

New York’s Medicaid program provides health coverage to lower-income New Yorkers. Medicaid pays for a wide range of services, depending on your age, financial resources, family situation, and living arrangements.

**Centers Plan for Dual Coverage Care** serves individuals who are entitled to both Medicare and medical assistance from New York State Medicaid.

In order to join **Centers Plan for Dual Coverage Care**, you must:

- Be enrolled in Medicare Parts A (hospital insurance); B (medical insurance); and D (prescription drug insurance)
- Be eligible for the New York State Medicaid Program OR eligible for Medicare and Medicare cost-sharing assistance under Medicaid
- Live in our service area: Bronx, Kings, Nassau, New York, Queens, Richmond, and Rockland Counties



## PREMIUMS AND DEDUCTIBLES

**Extra Help** is a Medicare program that helps people with limited incomes and resources reduce their Medicare Part D prescription drug costs such as premiums, deductibles, and copayments. Extra Help is also called the “Low-Income Subsidy” or “LIS.” Your prescription drug copayments under our plan already include the amount of Extra Help you qualify for. For more information about Extra Help, contact your local Social Security Office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. These calls are free.

Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
Monthly Plan Premium	Premium is the amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.	\$48.70 per month for your medical (Part C) and prescription drug (Part D) premiums combined	You must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medicaid or another third party.
Deductible	Deductible is the amount you pay during a coverage period (usually one year) for covered health	\$0 or \$240 per year for your medical (Part B) deductible	Cost sharing is based on your level of Extra Help or assistance from Medicaid.



2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
Deductible (cont.)	care services before your plan begins to pay.	<p>\$1,632 per benefit period for inpatient hospital services</p> <p>\$1,632 per benefit period for inpatient hospital psychiatric services</p> <p>\$0 or \$545 per year for your prescription drug (Part D) deductible</p>	<p>A benefit period begins the day you are admitted as an inpatient and ends when you have not received any inpatient care for 60 days in a row.</p> <p>There is no deductible for covered insulin products and most adult Part D vaccines.</p>
Maximum Out-of-Pocket (MOOP) Responsibility	Out-of-Pocket Limit (also known as Maximum Out-of-Pocket Responsibility) is the most you could pay during a coverage period (usually one year)	No more than \$8,850 annually	Your out-of-pocket limit does not include Part D prescription drug costs.

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

<b>Health Insurance Term</b>	<b>Definition</b>	<b>Your costs</b>	<b>Limitations, exceptions, and other information</b>
Maximum Out-of-Pocket Responsibility (cont.)	for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs.		

## MEDICARE-COVERED HEALTH SERVICES AND YOUR COSTS

Please note that services marked with an \* are supplemental benefits covered by our plan.

### If you need hospital care

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Inpatient Hospital Coverage	<p>For each benefit period:</p> <ul style="list-style-type: none"> <li>• \$1,632 deductible</li> <li>• \$0 for days 1 through 60</li> <li>• \$408 per day, for days 61 through 90</li> <li>• \$816 for each of 60 lifetime reserve days</li> <li>• Beyond lifetime reserve days, you pay all costs</li> </ul>	<p><i>A benefit period begins the day you are admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins.</i></p> <p style="text-align: center;"><b>Authorization is required</b></p>

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

**If you need hospital care (cont.)**

<b>Services you may need</b>	<b>Costs you pay for using in-network providers</b>	<b>Limitations, exceptions, and other benefit information (rules about benefits)</b>
Outpatient Hospital Coverage, including Observation Services	\$0 or 20% coinsurance	Coverage of whole blood and packed red cells begins with the first pint of blood you need. The three (3) pint deductible is waived. <b>Authorization is required</b>
Ambulatory Surgery Center (ASC)	\$0 or 20% coinsurance	<b>Authorization is required</b>

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

**If you need to see a doctor**

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Primary Care Provider (PCP) Visit	\$0 or 20% coinsurance per visit	
Specialist Visit	\$0 or 20% coinsurance per visit	
Preventive Care, such as screenings, vaccinations, and wellness visits	\$0	<p><b>Authorization may be required</b> for some preventive care services.</p> <p><b>Important Message About What You Pay for Vaccines –</b> Our plan covers most Part D vaccines at no cost to you, even if you have not paid your deductible. Call Member Services for more information.</p>

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

**If you need immediate medical attention**

<b>Services you may need</b>	<b>Costs you pay for using in-network providers</b>	<b>Limitations, exceptions, and other benefit information (rules about benefits)</b>
Emergency Care	\$0 or 20% coinsurance per visit up to a maximum of \$90 for care received in the United States	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost of emergency care.
Emergency Care (cont.)	\$0 per worldwide emergency care visit	The Worldwide Coverage maximum benefit amount is \$25,000.
Urgently Needed Services	\$0 or 20% coinsurance per visit up to a maximum of \$55	If you are admitted to the hospital within 24 hours with the same condition, you do not have to pay your share of the urgently needed services. Urgently needed services are only covered in the United States and its territories.

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

**If you need medical tests**

<b>Services you may need</b>	<b>Costs you pay for using in-network providers</b>	<b>Limitations, exceptions, and other benefit information (rules about benefits)</b>
Diagnostic Tests and Procedures	\$0 or 20% coinsurance	<b>Authorization is required</b>
Lab Services	\$0	<b>Authorization is required</b>
Diagnostic Radiology, such as MRIs and CT scans	\$0 or 20% coinsurance	<b>Authorization is required</b>
Therapeutic Radiology, such as radiation treatment for cancer	\$0 or 20% coinsurance	<b>Authorization is required</b>
X-Rays	\$0 or 20% coinsurance	<b>Authorization is required</b>

**If you need hearing/audiological services**

<b>Services you may need</b>	<b>Costs you pay for using in-network providers</b>	<b>Limitations, exceptions, and other benefit information (rules about benefits)</b>
Hearing Services (Diagnostic Hearing and Balance Evaluations)	\$0 or 20% coinsurance	



2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

**If you need hearing/audiological services (cont.)**

<b>Services you may need</b>	<b>Costs you pay for using in-network providers</b>	<b>Limitations, exceptions, and other benefit information (rules about benefits)</b>
Routine Hearing Exam*	\$0	We cover one routine hearing exam per year.
Hearing Aid Fitting/Evaluation*	\$0	We cover one hearing aid fitting/evaluation every three (3) years.
Hearing Aids*	\$0	We pay up to \$1,000, per ear, every three (3) years for hearing aids.

**If you need dental care**

<b>Services you may need</b>	<b>Costs you pay for using in-network providers</b>	<b>Limitations, exceptions, and other benefit information (rules about benefits)</b>
Medicare Part A Dental Services	20% coinsurance	Like Medicare Part A (hospital insurance), we cover certain dental services that you get when you're in a hospital and hospital stays if you need to have emergency or complicated dental procedures.
Preventive Dental Services*	\$0	We cover each service once every six months: <ul style="list-style-type: none"> <li>● Dental Cleaning (Prophylaxis)</li> <li>● Dental X-Rays</li> <li>● Fluoride Treatment</li> <li>● Oral Exam</li> </ul>

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

**If you need dental care (cont.)**

<b>Services you may need</b>	<b>Costs you pay for using in-network providers</b>	<b>Limitations, exceptions, and other benefit information (rules about benefits)</b>
Comprehensive Dental Services*	\$0	<p>Comprehensive dental services are limited to \$2,000 per year. We cover:</p> <ul style="list-style-type: none"> <li>• Crowns and Posts (one every 60 months per tooth)</li> <li>• Dentures (one per 36 months)</li> <li>• Denture repairs (one per 12 months)</li> <li>• Endodontics, such as root canals (one per lifetime per tooth)</li> <li>• Extractions (1 per lifetime per tooth)</li> <li>• Fillings (one every 24 months per tooth)</li> <li>• Gingivectomies (one per 36 months per quadrant)</li> <li>• Occlusal Guards, such as night guards (one per 12 months)</li> <li>• Periodontal maintenance (one every six months)</li> <li>• Prosthodontic Services (one every 36 months per arch)</li> <li>• Scaling (one every six months per quadrant)</li> </ul>

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

**If you need vision care**

Services you may need	Costs you pay for in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Routine Eye Exam*	\$0	We cover one routine eye exam per year.
Eyewear*	Any costs for eyewear above \$200 per year	<ul style="list-style-type: none"> <li>• We cover up to \$200 per year for eyeglasses or contact lenses.</li> <li>• Eyeglasses are limited to one pair of eyeglasses (lenses and frames) per year.</li> </ul>
Medicare Part B Eye Health Services	\$0 or 20% coinsurance	Like Medicare Part B (medical insurance), we cover certain exams and treatments for specific conditions.
Eyewear for Specific Conditions	\$0	We cover one pair of eyeglasses or contact lenses after each cataract surgery that implants an intraocular lens.

**If you need mental health services**

Services you may need	Costs you pay for in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Inpatient Mental Health Care	<p>For each benefit period:</p> <ul style="list-style-type: none"> <li>• \$1,632 deductible</li> <li>• \$0 for days 1 through 60</li> <li>• \$408 for days 61 through 90</li> <li>• \$816 for each of 60 lifetime reserve days</li> <li>• Beyond lifetime reserve days, you pay all costs</li> <li>• 20% coinsurance for mental health services you get from doctors and other health care providers while you're a hospital inpatient</li> </ul>	<p><i>A benefit period begins the day you are admitted as an inpatient and ends when you have not received any inpatient care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins.</i></p> <p><b>Authorization is required</b></p>

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

**If you need mental health services (cont.)**

Services you may need	Costs you pay for in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Outpatient Therapy	\$0 or 20% coinsurance per individual or group session	<b>Referral is required for Psychiatric services</b>

**If you need rehabilitation or therapy services**

Services you may need	Costs you pay for in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Skilled Nursing Facility (SNF) care	For each benefit period: <ul style="list-style-type: none"> <li>• \$0 for days 1 through 20</li> <li>• \$204 copayment per day, for days 21 through 100</li> <li>• All costs for each day after day 100 of the benefit period.</li> </ul>	<p><i>The benefit period ends when you have not received skilled care in a SNF (up to 100 days) for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins.</i></p> <p>A 3-day qualifying stay in a hospital is not required.</p> <p><b>Authorization is required</b></p>

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

**If you need rehabilitation or therapy services (cont.)**

Services you may need	Costs you pay for in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Physical, Occupational, and/or Speech Therapy	\$0 or 20% coinsurance per visit	<b>Authorization is required</b>

**If you need transportation**

Services you may need	Costs you pay for in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Ambulance	\$0 or 20% coinsurance per trip	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for ambulance services. <b>Authorization is required for non-emergency services</b>
Non-Emergency Medical Transportation (NEMT)*	\$0	We cover ten (10) one-way trips every three (3) months to plan-approved, health-related locations via bus, subway, van, or medical transport. <b>Authorization is required</b>

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

**If you need outpatient prescription drugs (i.e., medicine you would get in a doctor’s office or in an outpatient hospital setting)**

Services you may need	Costs you pay for in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Medicare Part B Drugs	<p>0% to 20% coinsurance for Medicare-covered Part B prescription drugs</p> <p>You pay no more than \$35 for a one-month supply of each Part B insulin product covered by our plan</p>	<p>Like Medicare Part B (medical insurance), we cover a limited number of outpatient prescription drugs under certain conditions, such as those you get at a doctor's office or in a hospital outpatient setting.</p> <p><b>Authorization is required</b></p>



## PRESCRIPTION DRUG STAGES AND YOUR COSTS

Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
Deductible (Stage 1)	Deductible is the amount you pay during a coverage period (usually one year) for prescription drugs before your plan begins to pay.	Your prescription drug (Part D) deductible is \$0 or \$545 per year.	Your deductible amount depends on the level of “Extra Help” you receive. (Look at the separate insert, the LIS Rider, for your deductible amount.)
Initial Coverage Phase (Stage 2)	Initial Coverage Phase is the stage that begins when you fill your first prescription and ends when your year-to-date total prescription drug costs reach the phase threshold.	During this stage, for generic drugs, you pay \$0, \$1.55, \$4.50 copayment or no more than 25% coinsurance per prescription. For all other drugs, you pay \$0, \$4.60, \$11.20 copayment or no more than 25% coinsurance per prescription.	Cost sharing is based on your level of Extra Help or assistance from Medicaid.  Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage).

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
Initial Coverage Phase (Stage 2) (cont)		You pay no more than \$35 per month supply of each covered insulin product.	
Coverage Gap (Stage 3)	Coverage Gap is a period of time in which you pay higher cost sharing for prescription drugs until you spend enough to qualify for catastrophic coverage. The coverage gap is also called the “donut hole.”	When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer	You continue paying these costs until your yearly out-of-pocket payments reach \$8,000. Once you reach this amount, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage. Medicare has rules about what counts and what does not count toward your out-of-pocket costs.

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
Coverage Gap (Stage 3) (cont)		<p>count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. Only the amount you pay counts and moves you through the coverage gap.</p>	

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

<b>Health Insurance Term</b>	<b>Definition</b>	<b>Your costs</b>	<b>Limitations, exceptions, and other information</b>
Catastrophic Coverage (Stage 4)	Catastrophic Coverage is a phase designed to protect you from having to pay very high out-of-pocket costs for prescription drugs. It usually begins after you have spent a pre-determined amount on your health care.	During this stage, you pay \$0 for covered Part D drugs (i.e., we will pay the full cost of your covered Part D drugs).	You enter this stage when your total year-to-date out-of-pocket costs are more than \$8,000.

## ADDITIONAL HEALTH SERVICES AND YOUR COSTS

### If you need additional services

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Acupuncture for chronic low back pain	<p>\$0 or 20% coinsurance per visit for up to 12 visits in 90 days for chronic low back pain.</p> <p>Medicare covers an additional 8 visits if improvement is demonstrated, with an annual limit of 20 visits.</p>	<p>Medicare-covered acupuncture is only covered under certain circumstances.</p> <p><b>Authorization is required for Visits 13 through 20</b></p>
Cardiac and Pulmonary Rehabilitation Services	<p>\$0 or 20% coinsurance</p>	<p>We cover Medicare-covered services.</p> <p><b>Authorization is required</b></p>
Chiropractic Care	<p>\$0 or 20% coinsurance for manual manipulation of the spine to correct a subluxation, which is when one or more of the bones of your spine move out of position</p>	<p>We cover Medicare-covered services.</p> <p><b>Authorization and referral are required</b></p>

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

**If you need additional services (cont.)**

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Diabetes Self-Management Training	\$0	<b>Authorization is required</b>
Diabetes Supplies and Services	\$0	<p>We cover Medicare-covered diabetic supplies and therapeutic shoes or inserts. Quantity limits apply to non-Part D diabetic supplies:</p> <ul style="list-style-type: none"> <li>• If you use insulin, we cover up to 150 test strips and 150 lancets every 30 days.</li> <li>• If you don't use insulin, we cover up to 100 test strips and 100 lancets every 90 days.</li> </ul> <p>Diabetes supplies and services are limited to a specific manufacturer, Abbott Diabetes Care.</p>
Durable Medical Equipment (DME)	\$0 or 20% coinsurance	<b>Authorization is required</b>

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

**If you need additional services (cont.)**

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Home Health Care	\$0	<b>Authorization is required</b>
Hospice	\$0	<b>Hospice is covered outside our plan.</b> You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Please contact Member Services for more details.
Kidney Disease Education Services	\$0	<b>Authorization is required</b>
Opioid Treatment Services	\$0	<b>Authorization is required</b>
Outpatient Substance Abuse Services	\$0 or 20% coinsurance per individual or group session	<b>Authorization is required</b>



2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

**If you need additional services (cont.)**

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Over-the-Counter (OTC) Items*	\$0	<p>You may purchase up to \$190 every month of eligible OTC items using your OTC debit card.</p> <p>Unused amounts cannot be carried over from month to month.</p> <p>Please visit <a href="http://www.mybenefitscenter.com">www.mybenefitscenter.com</a> to see our list of covered OTC items.</p>
Podiatry Services – Medicare covered	\$0 or 20% coinsurance for Medicare-covered podiatry services	<p>We cover Medicare-covered podiatry services. <b>Authorization and referral are required</b></p>

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

**If you need additional services (cont.)**

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Podiatry Services – Routine Foot Care*	\$0 copayment per visit for up to four (4) routine foot care visits per year	<b>Authorization and referral are required</b>
Prosthetic Devices, such as braces and artificial limbs	\$0 or 20% coinsurance	<b>Authorization is required</b>
Special Supplemental Benefits for the Chronically Ill/SSBCI: Blood Pressure Monitor*	\$0	<p>Eligible members (i.e., members with certain chronic conditions) may receive a blood pressure monitor once per year, based on medical necessity.</p> <p>This benefit is a Special Supplemental Benefit for the Chronically Ill (SSBCI), and <b>not all members will qualify.</b></p> <p>Please contact your Care Manager and/or refer to the <i>2024 Evidence of Coverage</i>, available at <a href="http://www.centersplan.com/dsnp">www.centersplan.com/dsnp</a>, for more information.</p>

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

**If you need additional services (cont.)**

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Special Supplemental Benefits for the Chronically Ill/SSBCI: Utilities Benefit*	\$0	<p>Eligible members (i.e., members with certain chronic conditions) may spend their \$190 monthly OTC allowance on OTC items and/or utilities (e.g., electric, gas, heating oil, water, landline phone, and internet).</p> <p>This benefit is a Special Supplemental Benefit for the Chronically Ill (SSBCI), and <b>not all members will qualify.</b></p> <p>Please contact your Care Manager and/or refer to the <i>2024 Evidence of Coverage</i>, available at <a href="http://www.centersplan.com/dsnp">www.centersplan.com/dsnp</a>, for more information.</p>

**If you need additional services (cont.)**

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	\$0	<b>Authorization is required</b>
Worldwide Emergency Coverage*	\$0	The Worldwide Coverage maximum benefit amount is \$25,000.

**MEDICAID-COVERED HEALTH SERVICES**

Dual eligible individuals are people who qualify for both Medicare and Medicaid. As a dual eligible individual, you are eligible for benefits under both the Federal Medicare program as well as the New York State Medicaid program. The Original Medicare and supplemental benefits you receive as a member of this plan can be found earlier in this booklet.

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 individuals do not have to pay for certain Medicare costs. To get information from Medicaid you can call NY State Department of Health (the Official Health Plan Marketplace) at 1-855-355-5777 (TTY users should call 1-800-662-1220); the New York State Medicaid Helpline at 1-800-541-2831; or New York City Human Resources

## 2024 SUMMARY OF BENEFITS – Centers Plan for Dual Coverage Care (HMO D-SNP)

---

Administration (HRA) Medicaid Helpline at 1-888-692-6116 or 1-718-557-1399. TTY users should call 711. If you reside outside of New York City, please call your local department of social services (LDSS). Please visit [https://www.health.ny.gov/health\\_care/medicaid/ldss.htm](https://www.health.ny.gov/health_care/medicaid/ldss.htm) to find the LDSS for your county.

The Medicaid benefit categories and types of assistance served by our plan are as follows:

- **Full Benefit Dual Eligible (FBDE):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). These individuals are also eligible for full Medicaid benefits.
- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums
- **Qualified Disabled and Working Individuals (QDWI):** Helps pay Part A premiums.

**What you pay for the Medicaid-covered services listed below depends on your level of Medicaid eligibility.**

2024 SUMMARY OF BENEFITS –  
Centers Plan for Dual Coverage Care (HMO D-SNP)

---

**If you need Medicaid services<sup>1</sup>**

<b>Services you may need</b>	<b>New York State Fee-For-Service Medicaid Benefit Information</b>
Adult Day Health Care	Medicaid coverage provided
Ambulance Services	Medicaid covers Medicare deductibles, copayments, and coinsurances.
Dental Care	Medicaid covers Medicare deductibles, copayments, and coinsurances. Medicaid covered dental services including necessary preventive, prophylactic and other routine dental care, services, and supplies and dental prosthetics to alleviate a serious health condition. Ambulatory or inpatient surgical dental services subject to prior authorization.
Diagnostic Tests, X- Rays, Lab Services, and Radiology Services	Medicaid covers Medicare deductibles, copayments, and coinsurances.
Emergency Care	Medicaid covers Medicare deductibles, copayments, and coinsurances.
Chronic Renal Dialysis	Medicaid covers Medicare deductibles, copayments, and coinsurances.
Hospice	Medicaid covers Medicare deductibles, copayments, and coinsurances.

---

<sup>1</sup> These services are not covered by Centers Plan for Dual Coverage Care, but are available through Medicaid. This is not a complete list Medicaid-covered services.

**If you need Medicaid services<sup>2</sup> (cont.)**

<b>Services you may need</b>	<b>New York State Fee-For-Service Medicaid Benefit Information</b>
Inpatient and Outpatient Hospital Services	Medicaid covers Medicare deductibles, copayments, and coinsurances.
Inpatient Mental Health Services (over 190-day lifetime limit)	Medicaid covers Medicare deductibles, copayments, and coinsurances. All inpatient mental health services, including voluntary or involuntary admissions for mental health services over the Medicare 190-day lifetime limit.
Medicaid Pharmacy Benefits (Prescription Drugs)	Medicaid does not cover Part D covered drugs or copayments.  NYS Medicaid provides coverage for certain drugs excluded from the Medicare Part D benefit such as barbiturates, benzodiazepines, and some prescription vitamins, and some non-prescription drugs.
Medical and Surgical Supplies, Enteral and Parenteral Formula and Hearing Aid Batteries	These items are generally considered to be one-time only use, consumable items routinely paid for under the Durable Medical Equipment category of fee-for-service Medicaid.

---

<sup>2</sup> These services are not covered by Centers Plan for Dual Coverage Care, but are available through Medicaid. This is not a complete list Medicaid-covered services.

**If you need Medicaid services<sup>3</sup> (cont.)**

<b>Services you may need</b>	<b>New York State Fee-For-Service Medicaid Benefit Information</b>
Medical and Surgical Supplies, Enteral and Parenteral Formula and Hearing Aid Batteries (cont.)	Coverage of enteral formula and nutritional supplements are limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding. Coverage of enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and to the following three conditions: 1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means; and, 3) children who require medical formulas due to mitigating factors in growth and development. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.

---

<sup>3</sup> These services are not covered by Centers Plan for Dual Coverage Care, but are available through Medicaid. This is not a complete list Medicaid-covered services.



**If you need Medicaid services<sup>4</sup> (cont.)**

<b>Services you may need</b>	<b>New York State Fee-For-Service Medicaid Benefit Information</b>
Mental Health Services	<p>Medicaid coverage of certain mental health services, including:</p> <ul style="list-style-type: none"> <li>• Intensive Psychiatric Rehabilitation Treatment Programs,</li> <li>• Day Treatment,</li> <li>• Continuing Day Treatment,</li> <li>• Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units),</li> <li>• Partial Hospitalizations,</li> <li>• Assertive Community Treatment (ACT),</li> </ul> <p>Personalized Recovery Oriented Services (PROS)</p>
Non-Emergency Transportation (NEMT)	<p>Medicaid covers Medicare deductibles, copayments, and coinsurances.</p> <p>Transportation expenses are covered when transportation is essential for a member to obtain necessary medical care and services which are covered under the Medicaid program.</p> <p>Transportation services means transportation by ambulance, ambulette, fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation, or other means appropriate to the Member’s medical condition.</p>

---

<sup>4</sup> These services are not covered by Centers Plan for Dual Coverage Care, but are available through Medicaid. This is not a complete list Medicaid-covered services.

**If you need Medicaid services<sup>5</sup> (cont.)**

<b>Services you may need</b>	<b>New York State Fee-For-Service Medicaid Benefit Information</b>
Non-Medicare Covered Care in Skilled Nursing Facility (SNF)	Medicaid covers Medicare deductibles, copayments, and coinsurances. Medicaid covers additional days beyond Medicare 100-day limit.
Non-Medicare Covered Durable Medical Equipment	Medicaid covered durable medical equipment, including devices and equipment other than medical/ surgical supplies, enteral formula and prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury and are usually fitted, designed, or fashioned for a particular individual's use. Must be ordered by a practitioner. No homebound prerequisite and including non-Medicare DME covered by Medicaid (e.g., tub stool or grab bar)
Non-Medicare Covered Home Health Services	Medically necessary intermittent skilled nursing care, home health aide services and rehabilitation services. Also includes non-Medicare covered home health services (e.g., home health aide services with nursing supervision to medically unstable individuals)

---

<sup>5</sup> These services are not covered by Centers Plan for Dual Coverage Care, but are available through Medicaid. This is not a complete list Medicaid-covered services.

**If you need Medicaid services<sup>6</sup> (cont.)**

<b>Services you may need</b>	<b>New York State Fee-For-Service Medicaid Benefit Information</b>
Non-Medicare Covered Vision Services	<p>Medicaid covers Medicare deductibles, copayments, and coinsurances.</p> <p>Services of Optometrists, Ophthalmologists, and Ophthalmic dispensers including eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services.</p> <p>Coverage also includes the repair or replacement of parts. Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged, or destroyed.</p>

---

<sup>6</sup> These services are not covered by Centers Plan for Dual Coverage Care, but are available through Medicaid. This is not a complete list Medicaid-covered services.

**If you need Medicaid services<sup>7</sup> (cont.)**

<b>Services you may need</b>	<b>New York State Fee-For-Service Medicaid Benefit Information</b>
Outpatient Rehabilitation Services	Medicaid covers Medicare deductibles, copayments, and coinsurances. Occupational, Physical and Speech therapies are limited to twenty (20) visits per therapy per year, except for children under age 21 and the developmentally disabled.
Over the Counter (OTC) Drugs	Certain OTC medications are covered.
Personal Care Services	Medicaid coverage provided Provides some or total assistance with such activities as personal hygiene, dressing and feeding and nutritional and environmental support function tasks (e.g., meal preparation). Services must be medically necessary and ordered by the enrollee’s physician and provided by a qualified person in accordance with a plan of care.
Personal Emergency Response Services (PERS)	Medicaid coverage provided An electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional, or environmental emergency.

---

<sup>7</sup> These services are not covered by Centers Plan for Dual Coverage Care, but are available through Medicaid. This is not a complete list Medicaid-covered services.

**If you need Medicaid services<sup>8</sup> (cont.)**

<b>Services you may need</b>	<b>New York State Fee-For-Service Medicaid Benefit Information</b>
Personal Emergency Response Services (PERS) (cont.)	A variety of electronic alert systems exist using different signaling devices. Such systems are usually connected to a patient’s phone and signal a response center when a “help” button is activated. In the event of an emergency, the signal is received and appropriately acted on by a response center.
Private Duty Nursing Services	Private duty nursing services are covered when determined by the physician to be medically necessary. Nursing services can be provided through an approved certified home health agency, a licensed home care agency, or a private practitioner. Nursing services may be intermittent, part time, or continuous and must be provided in an Enrollee's home in accordance with the ordering physician, registered physician assistant or certified nurse practitioner's written treatment plan. Private duty nursing services must be provided by a person possessing a license and current registration from the NYS Education Department to practice as a registered professional nurse or licensed practical nurse.

---

<sup>8</sup> These services are not covered by Centers Plan for Dual Coverage Care, but are available through Medicaid. This is not a complete list Medicaid-covered services.

**If you need Medicaid services<sup>9</sup> (cont.)**

<b>Services you may need</b>	<b>New York State Fee-For-Service Medicaid Benefit Information</b>
Prosthetic Devices	Medicaid covers Medicare deductibles, copayments, and coinsurances. Medicaid covered prescription footwear is limited to treatment of diabetics, or when shoe is part of a leg brace (orthotic), or if there are foot complications in children under age 21. Compression and support stockings are limited to coverage only for pregnancy or treatment for venous stasis ulcers.
Other Services	All other services listed in the Title XIX New York State Plan.

---

<sup>9</sup> These services are not covered by Centers Plan for Dual Coverage Care, but are available through Medicaid. This is not a complete list Medicaid-covered services.



## Language Assistance Services Notification

English	<p>We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-940-9330 (TTY: 711). Someone who speaks English can help you. This is a free service.</p>
Albanian	<p>Ne kemi në dispozicion shërbime përkthimi për t'ju përgjigjiur çdo pyetjeje që mund të keni lidhur me shëndetin tuaj apo me planin tuaj të mjekimit. Për të siguruar një përkthyes/e, na telefononi në 1-877-940-9330 (TTY: 711). Dikush që flet shqip mund t'ju ndihmojë. Ky është një shërbim pa pagesë.</p>
Arabic	<p>لدينا خدمات ترجمة فورية مجانية للإجابة عن أي أسئلة قد تراودك بشأن خطتنا للصحة أو الأدوية. للحصول على مترجم فوري، اتصل بنا فحسب على الرقم 1-877-940-9330 (لمستخدمي الهاتف النصي: 711). يمكن لشخص يتحدث العربية مساعدتك. هذه خدمة مجانية.</p>
Bengali	<p>আমাদের স্বাস্থ্য বা ওষুধ পরিকল্পনা সম্পর্কে আপনার যে কোনো প্রশ্নের উত্তর দেওয়ার জন্য আমাদের বিনামূল্যে দোভাষী পরিষেবা রয়েছে। দোভাষী পেতে হলে, আমাদের কেবল 1-877-940-9330 (TTY: 711) -এ কল করে যোগাযোগ করুন। বাংলাভাষী কেউ আপনাকে সাহায্য করতে পারেন। এটি বিনামূল্যে প্রাপ্ত পরিষেবা।</p>
Chinese	<p>我們可提供免費口譯服務，回答您在健康或藥物計劃方面的任何問題。如需翻譯服務，只需致電我們的電話：<b>1-877-940-9330 (TTY: 711)</b>。漢語說英語的工作人員可為您提供幫助。這是一項免費服務。</p>



French	Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pouvez avoir sur notre régime d'assurance-maladie ou d'assurance-médicaments. Pour obtenir un interprète, il suffit de nous appeler au 1-877-940-9330 (TTY : 711). Une personne qui parle français peut vous aider. Il s'agit d'un service gratuit.
French Creole	Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen konsènan plan sante ak medikaman nou an. Pou w jwenn yon entèprèt, annik rele nou nan 1-877-940-9330 (TTY: 711). Yon moun ki pale Kreyòl Ayisyen ka ede w. Sèvis sa a gratis.
German	Wir bieten Ihnen einen kostenlosen Dolmetscherdienst, um alle Ihre Fragen zu unserem Gesundheits- oder Medikamentenplan zu beantworten. Für einen Dolmetscher, rufen Sie uns einfach unter der Rufnummer 1-877-940-9330 (TTY: 711) an. Eine Person, die Deutsch spricht, kann Ihnen helfen. Dies ist ein kostenloser Dienst.
Greek	Διαθέτουμε δωρεάν υπηρεσίες διερμηνείας για να απαντήσουμε σε τυχόν ερωτήσεις μπορεί να έχετε σχετικά με το πλάνο ιατρικής ή φαρμακευτικής περίθαλψής μας. Για να επικοινωνήσετε με διερμηνέα, απλώς καλέστε μας στο 1-877-940-9330 (TTY: 711). Κάποιος που μιλάει Ελληνικά μπορεί να σας βοηθήσει. Αυτή είναι μια δωρεάν υπηρεσία.
Hindi	हमारे स्वास्थ्य या ड्रग योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं हैं। दुभाषिया की सेवा प्राप्त करने के लिए, हमें 1-877-940-9330 (TTY: 711) पर कॉल करें। हिंदीअंग्रेज़ी जानने वाला कोई व्यक्ति आपकी सहायता कर सकता है। यह निशुल्क सेवा है।

Italian	Disponiamo di servizi di interpretariato gratuiti per eventuali domande sul nostro piano di assistenza sanitaria e farmaceutica. Per ricevere il supporto di un interprete, chiamare il numero 1-877-940-9330 (TTY: 711). Sarà disponibile qualcuno che parli italiano. Il servizio è gratuito.
Japanese	弊社の健康および薬品に対するプランについて、お客様がお尋ねになりたいすべてのご質問にお答えするため弊社は無料通訳サービスを用意しております。通訳サービスを受けるには、弊社までお電話ください：1-877-940-9330（TTY: 711）。日本語が話せる方がお手伝いします。こうしたサービスは無料です。
Korean	귀하의 건강 또는 약품 플랜에 대한 질문에 답변해드리는 무료 통역 서비스를 제공합니다. 통역사를 구하려면 1-877-940-9330(TTY: 711) 번으로 전화하십시오. 한국어를 할 줄 아는 사람이 도와줄 수 있습니다. 이 서비스는 무료입니다.
Polish	Oferujemy bezpłatne usługi tłumacza, który odpowie na wszelkie pytania dotyczące naszego planu zdrowotnego lub planu przyjmowania leków. Aby uzyskać pomoc tłumacza, wystarczy zadzwonić pod numer 1-877-940-9330 (TTY: 711). Pomocy udzieli osoba mówiąca po Polskie. Usługa jest bezpłatna.
Portuguese	Contamos com serviços gratuitos de interpretação para sanar suas dúvidas sobre o plano de saúde ou medicamentos. Para conseguir um intérprete, entre em contato conosco pelo 1-877-940-9330 (TTY: 711). Alguém que fala português irá ajudá-lo. Este serviço é gratuito.

Russian	Мы предоставляем бесплатные услуги переводчика, чтобы ответить на любые ваши вопросы о нашем плане медицинского обслуживания или программе лекарственных препаратов. Чтобы воспользоваться услугами переводчика, просто позвоните нам по телефону 1-877-940-9330 (TTY: 711). Вам может помочь русскоязычный человек. Это бесплатная услуга.
Spanish	Contamos con servicios de interpretación gratuitos para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para recibir la ayuda de un intérprete, llámenos al 1-877-940-9330 (TTY: 711). Alguien que hable español puede ayudarle. Éste es un servicio gratuito.
Tagalog	Mayroon kaming mga libreng serbisyo ng pag-interpret upang sagutin ang mga katanungan mo tungkol sa kalusugan o plano sa paggagamot. Para makakuha ng taga-interpret, tawagan kami sa 1-877-940-9330 (TTY: 711). Taong nagsasalita ng tagalog ang makakatulong sa iyo. Ito ay libreng serbisyo.
Urdu	ہمارے ہیلتھ یا ڈرگ پلان کے بارے میں آپ کے کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مفت ترجمان کی خدمات ہیں۔ ترجمان حاصل کرنے کے لیے، ہمیں 1-877-940-9330 (TTY: 711) پر کال کریں۔ کوئی اردو بولنے والا آپ کی مدد کر سکتا ہے۔ یہ مفت خدمت ہے۔
Vietnamese	Chúng tôi có dịch vụ thông dịch miễn phí để trả lời mọi câu hỏi về chương trình bảo hiểm y tế hoặc thuốc của chúng tôi. Để yêu cầu người thông dịch, chỉ cần gọi cho chúng tôi theo số 1-877-940-9330 (TTY: 711). Ai đó nói tiếng Việt có thể giúp bạn. Đây là dịch vụ miễn phí.
Yiddish	מיר האבן אומזיסטע איבערזעצונג סערוויסעס צו ענטפערן סיי וועלכע פראגעס וואס איר קענט האבן וועגן אייער געזונטהייט אדער דראג פלאן. צו באקומען אן איבערזעצער, רופט אונז ביי 1-877-940-9330 (TTY: 711). איינער וואס רעדט אידיש קען אייך העלפן. דאס איז אן אומזיסטע סערוויס.

## Notice of Nondiscrimination

### Discrimination is Against the Law

Centers Plan for Healthy Living, LLC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Centers Plan for Healthy Living, LLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Centers Plan for Healthy Living, LLC provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at 1-877-940-9330 (TTY users please call 711).

If you believe that Centers Plan for Healthy Living, LLC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Grievances and Appeals Department:

By Mail:           Centers Plan for Healthy Living, LLC  
                          Attn: G&A Department  
                          75 Vanderbilt Avenue, 7<sup>th</sup> Floor  
                          Staten Island, NY 10304- 2604

By Phone: 1-877-940-9330 (TTY users call 711)  
By Fax: 1-347-505-7089  
By Email: [GandA@centersplan.com](mailto:GandA@centersplan.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you seven days a week, from 8 am to 8 pm.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.





For More Information or to Enroll  
Call 1-877-940-9330 (toll free)

TTY Users call 711

Seven days a week, 8 am to 8 pm

[MemberServices@centersplan.com](mailto:MemberServices@centersplan.com)

[www.centersplan.com/dsnp](http://www.centersplan.com/dsnp)