2024

CENTERS PLAN FOR HEALTHY LIVING

Annual Notice of Changes

Centers Plan for Medicaid Advantage Plus (HMO D-SNP)

H6988-004_CY24ANOC_M

Language Assistance Services Notification

English	We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-274-5627 (TTY: 711). Someone who speaks English can help you. This is a free service.
Albanian	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 1-833-274-5627 (TTY: 711). Dikush që flet shqip mund t'ju ndihmojë. Ky është një shërbim pa pagesë.
Arabic	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 1-833-274-5627 (لمستخدمي الهاتف النصي: 711). يمكن لشخصٍ يتحدث العربية مساعدتك. هذه خدمة مجانية.
Bengali	আমাদের স্বাস্থ্য বা ওষুধ পরিকল্পনা সম্পর্কে আপনার যে কোনো প্রশ্নের উত্তর দেওয়ার জন্য আমাদের বিনামূল্যে দোভাষী পরিষেবা রয়েছে। দোভাষী পেতে হলে, আমাদের কেবল 1-833-274-5627 (TTY: 711) -এ কল করে যোগাযোগ করুন। বাংলাভাষী কেউ আপনাকে সাহায্য করতে পারেন। এটি বিনামূল্যে প্রাপ্ত পরিষেবা।
Chinese	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：1-833-274-5627 （TTY：711）。漢語說英語的工作人員可爲您提供幫助。這是一項免費服務。
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 1-833-274-5627 (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 1-833-274-5627 (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 1-833-274-5627 (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 1-833-274-5627 (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 1-833-274-5627 (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 1-833-274-5627 (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：1-833-274-5627 （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 1-833-274-5627 (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 1-833-274-5627 (TTY: 711). Pomocy udzieli osoba mówiąca po Polskie. Usługa jest bezpłatna.

Portugese	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 1-833-274-5627 (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 1-833-274-5627 (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 1-833-274-5627 (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 1-833-274-5627 (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 1-833-274-5627 (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 1-833-274-5627 (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 1-833-274-5627 (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 1-833-274-5627 (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, 7th Floor
Staten Island, NY 10304- 2604
By Phone: 1-833-274-5627 (TTY users call 711)
By Fax: 1-347-505-7089
By Email: GandA@centersplan.com

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

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.

Centers Plan for Medicaid Advantage Plus (HMO D-SNP) offered by Centers Plan for Healthy Living, LLC

Annual Notice of Changes for 2024

You are currently enrolled as a member of Centers Plan for Medicaid Advantage Plus. Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.centersplan.com/map. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

What to do now

1. ASK: Which changes apply to you

□ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2023, you will stay in Centers Plan for Medicaid Advantage Plus.
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with Centers Plan for Medicaid Advantage Plus.
- Look in section 2.2, page 24 to learn more about your choices.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-833-274-5627 for additional information. (TTY users should call 711.) Hours are seven days a week, from 8 am to 8 pm. This call is free.
- This information is available in different formats including braille and large print. Please call Member Services at the number listed above if you need plan information in another format or language.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Centers Plan for Medicaid Advantage Plus

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

OMB Approval 0938-1051 (Expires: February 29, 2024)

Annual Notice of Changes for 2024
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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Centers Plan for Medicaid Advantage Plus in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Deductible	$0	$0
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 per visit
Inpatient hospital stays	There is no coinsurance, copay, or deductible.	There is no coinsurance, copay, or deductible.

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays (cont.)	Our plan covers up to 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover at a $0 copay. If your hospital stay is longer than 90 days, you can use these extra days; but once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. If you get authorized inpatient care at an out-of-network	Our plan covers up to 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover at a $0 copay. If your hospital stay is longer than 90 days, you can use these extra days; but once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. If you get authorized inpatient care at an out-of-network

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays (cont.)	hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. **Authorization is required.**	hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. **Authorization is required.**
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/ Coinsurance* during the Initial Coverage Stage: • **Generic Drugs:** You pay $0 • **All Other Drugs:** You pay $0	Deductible: $0 Copayment/ Coinsurance during the Initial Coverage Stage: • **Generic Drugs:** You pay $0 • **All Other Drugs:** You pay $0

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (cont.)	*Cost-sharing is based on your level of "Extra Help"	
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$7,550 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$8,850 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0

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

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$7,550 Once you have paid $7,550 out-of-pocket for services, you will pay nothing for your covered services for the rest of the calendar year.	$8,850 Once you have paid $8,850 out-of-pocket for services, you will pay nothing for your covered services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.centersplan.com/map. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the *2024 Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the *2024 Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers), and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare and Medicaid benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Acupuncture for Chronic Lower Back Pain	You pay a $0 copayment per treatment. Up to 12 visits in 90 days are covered for Medicare beneficiaries with chronic low back pain. An additional eight sessions will be covered for Medicare beneficiaries demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Authorization is required.	You pay a $0 copayment per treatment. Up to 12 visits in 90 days are covered for Medicare beneficiaries with chronic low back pain. An additional eight sessions will be covered for Medicare beneficiaries demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. **Authorization is <u>not</u> required for visits 1-12.** **Authorization ***<u>is</u>* required for visits 13-20.**

Cost	2023 (this year)	2024 (next year)
Hearing Aids	There is no coinsurance, copayment, or deductible for hearing aids. We pay up to $700, per ear, every three (3) years.	There is no coinsurance, copayment, or deductible for hearing aids. We pay up to **$1,000**, per ear, every three (3) years.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies	You pay $0 copayment for Medicare-covered diagnostic tests, labs, x-rays, and radiology services. Authorization is required for diagnostic and therapeutic radiology services.	You pay $0 copayment for Medicare-covered diagnostic tests, labs, x-rays, and radiology services. **Authorization is required.**
Over-the-Counter (OTC) Benefit	The plan covers up to $255 per month of certain OTC items and food items (*if eligible*) on an OTC debit card. Unused amounts **cannot** be carried over from month to month.	You may purchase up to $290 every month of eligible OTC items using your OTC debit card. Unused amounts cannot be carried over from month to month.

Cost	2023 (this year)	2024 (next year)
Over-the-Counter (OTC) Benefit (cont.)	**Please note:** The $255 monthly OTC benefit is a combined (i.e., OTC and SSBCI benefits) monthly allowance which can also be used towards your food and produce benefit (*if you qualify*). This means that there is **only** one monthly allowance of $255 for both benefits. If you do not qualify for the food and produce benefit, the $255 monthly allowance can only be used on OTC items. Please visit our website (www.centersplan.com) or call Member Services at the number located on the back of this booklet for the list of covered items.	Please visit www.mybenefitscenter.com to see our list of covered OTC items. *For information about the Food & Produce benefit, please see the Special Supplemental Benefits for the Chronically Ill (SSBCI): Food, Produce, and Utilities section of this table.*

Cost	2023 (this year)	2024 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI): Blood Pressure Monitor	Blood pressure monitor was not a covered benefit.	Eligible members pay $0 copayment for one blood pressure monitor per year. To qualify for this SSBCI benefit, members must: • Be active participants in our Care Management Program; • Have a medical need for a blood pressure monitor; **AND** • Have been diagnosed with one or more of the following conditions: autoimmune disorders; cancer; cardiovascular disorders; chronic alcohol and other drug dependence; chronic and disabling mental health conditions; chronic heart failure; chronic kidney diseases; chronic liver diseases; chronic lung disorders; chronic

Cost	2023 (this year)	2024 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI): Blood Pressure Monitor (cont.)		malnutrition; dementia; diabetes; end-stage liver disease; end-stage renal disease (ESRD); HIV/AIDS; inflammatory bowel disease; neurologic disorders; severe hematologic disorders; stroke. The blood pressure monitor benefit mentioned in this document is a Special Supplemental Benefit for the Chronically Ill (SSBCI), and not all members will qualify. Please contact your Care Manager at 1-833-274-5627 (TTY users call 711) for more information.

Cost	2023 (this year)	2024 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI): Food, Produce, and Utilities	The plan covers up to $255 per month for food items, including but not limited to canned foods, frozen foods and produce and certain OTC items on an OTC debit card. Unused amounts **cannot** be carried over from month to month. **Please note:** The $255 monthly food and produce benefit (*if you qualify*) is a combined (i.e., OTC and SSBCI benefits) monthly allowance which can also be used towards your OTC benefit. This means that there is only one monthly allowance of $255 for both benefits. If you do not qualify for the food and produce benefit, the	The plan covers up to **$290** per month for food items (including but not limited to canned foods, frozen foods and produce), **utilities** (electric, gas, heating oil, water, landline phone, and internet) and certain OTC items on an OTC debit card. Unused amounts **cannot** be carried over from month to month. **Please note:** The **$290** monthly food and produce benefit allowance (*if you qualify*) is a combined (i.e., OTC and SSBCI benefits) monthly allowance which can also be used towards your OTC benefit. This means that there is only one monthly allowance of **$290** for **all three benefits**. If you do not qualify for the food, produce, and **utilities**

Cost	2023 (this year)	2024 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI): Food, Produce, and Utilities (cont.)	$255 monthly allowance can only be used on OTC items. If you are diagnosed with the following chronic condition(s) identified below and meet certain criteria, you may be eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI): autoimmune disorders; chronic alcohol and other drug dependence; cancer; cardiovascular disorders; chronic and disabling mental health conditions; chronic heart failure; chronic kidney disease; chronic liver disease; chronic lung disorders; dementia; diabetes; end-stage liver disease; end-stage renal disease (ESRD); HIV/AIDS;	benefit, the **$290** monthly allowance can only be used on OTC items. To qualify for this SSBCI benefit, members must: • Be active participants in our Care Management Program; **AND** • Have been diagnosed with one or more of the following conditions: autoimmune disorders; **cancer**; cardiovascular disorders; **chronic alcohol and other drug dependence**; **chronic and disabling mental health conditions**; chronic heart failure; chronic kidney diseases; **chronic liver diseases**; chronic lung disorders; **chronic malnutrition**; **dementia**; diabetes; **end-stage liver disease;**

Cost	2023 (this year)	2024 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI): Food, Produce, and Utilities (cont.)	inflammatory bowel disease; malnutrition; neurologic disorders; severe hematologic disorders; stroke; vitamin b12 deficiency anemia	end-stage renal disease (ESRD); **HIV/AIDS**; **inflammatory bowel disease**; neurologic disorders; **severe hematologic disorders**; stroke. The food, produce, and utilities benefit mentioned in this document is a Special Supplemental Benefit for the Chronically Ill (SSBCI), and not all members will qualify. Please contact your Care Manager at 1-833-274-5627 (TTY users call 711) for more information.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our "Drug List"

Our list of covered drugs is called a Formulary or "Drug List." A copy of our "Drug List" is provided electronically at www.centersplan.com/map.

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

Most of the changes in the "Drug List" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Changes to Prescription Drug Costs

If you receive "Extra Help" to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost sharing for Part D drugs. Some of the information described in this section may not apply to you. **Note:** If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs does not apply to you.**

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the

Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2023 to 2024.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Generic Drugs:** You pay: $0 **All Other Drugs:** You pay: $0	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Generic Drugs:** You pay: $0 **All Other Drugs:** You pay: $0

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued) The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	Once your total drug costs have reached **$4,660**, you will move to the next stage (the Coverage Gap Stage).	Once you have paid **$5,030** out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Centers Plan for Medicaid Advantage Plus

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Centers Plan for Medicaid Advantage Plus plan.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

As a reminder, Centers Plan for Healthy Living, LLC offers other Medicare health plans These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Centers Plan for Medicaid Advantage Plus.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Centers Plan for Medicaid Advantage Plus.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2024.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

Because you have New York State Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HIICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HIICAP at 1-800-701-0501. You can learn more about HIICAP by visiting their website https://aging.ny.gov/health-insurance-information-counselingand-assistance-program-hiicap.

For questions about your New York State Medicaid benefits, contact New York's Medicaid program at 1-888-692-6116 (TTY users call 711), Monday to Friday, 9am-5pm. Ask how joining another plan or returning to Original Medicare affects how you get your New York State Medicaid program coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles, and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. 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 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
  - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** New York State has a program called Elderly Pharmaceutical Insurance Coverage (EPIC) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low

income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the New York Department of Health's AIDS Institute. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-542-2437.

SECTION 6 Questions?

Section 6.1 – Getting Help from Centers Plan for Medicaid Advantage Plus

Questions? We're here to help. Please call Member Services at 1-833-274-5627. (TTY only, call 711.) We are available for phone calls seven days a week, from 8am-8pm. Calls to these numbers are free.

Read your *2024 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* for *Centers Plan for Medicaid Advantage Plus.* The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.centersplan.com/map. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.centersplan.com/map. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/Drug List)*.

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read Medicare & You 2024

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or 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.

Section 6.3 – Getting Help from Medicaid

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 Administration (HRA) Medicaid Helpline at 1-888-692-6116 or 1-718-557-1399. TTY users should call 711.

CENTERS PLAN FOR HEALTHY LIVING

For More Information or to Enroll
Call 1-833-274-5627 (toll free)
TTY Users call 711
Seven days a week, 8am-8pm
MemberServices@centersplan.com
www.centersplan.com/map