



2023 Summary of Benefits

Centers Plan for Nursing Home Care (HMO I-SNP)

January 1, 2023 - December 31, 2023

H6988, Plan 003

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

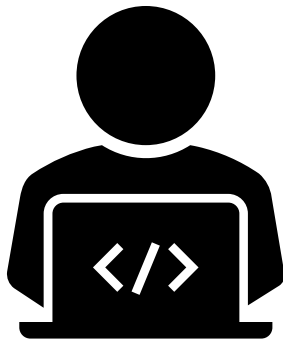


Buffalo
Erie and
Niagara
Counties

Hudson Valley
Rockland and
Westchester
Counties

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

Long Island
Nassau and Suffolk
Counties



Member Services can be reached via:

PHONE	1-877-940-9330 (TTY users, please call 711) 8:00 a.m. to 8:00 p.m., 7 days a week
WEBSITE	www.centersplan.com/isnp
EMAIL	MemberServices@centersplan.com
MAIL	Centers Plan for Healthy Living, LLC 75 Vanderbilt Avenue, 7 th Floor Staten Island, NY 10304

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.



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 Nursing Home Care**.



Centers Plan for Nursing Home Care (HMO I-SNP) is an HMO with a Medicare contract. Enrollment in Centers Plan for Nursing Home Care depends on contract renewal.



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/isnp.



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/isnp. 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 or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users, please call 1-877-486-2048.

ELIGIBILITY

Centers Plan for Nursing Home Care is a Medicare Advantage “Special Needs Plan” or “SNP,” which means its benefits, providers, and drug formularies are tailored to best meet the needs of people with specific medical conditions or characteristics.

Centers Plan for Nursing Home Care is designed specifically for people who live in a nursing home contracted with Centers Plan for Nursing Home Care.

In order to join **Centers Plan for Nursing Home Care**, you must:

- Be enrolled in Medicare Parts:
 - A (hospital insurance),
 - B (medical insurance), and
 - D (prescription drug insurance)

- Live in a nursing home **contracted with** Centers Plan for Nursing Home Care, located within our service area: Bronx, Erie, Kings, Nassau, New York, Niagara, Queens, Richmond, Rockland, Suffolk, and Westchester 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.

2023 SUMMARY OF BENEFITS – Centers Plan for Nursing Home Care (HMO I-SNP)

Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
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.	\$0 per month for your medical (Part C), and \$38.90 per month for prescription drug (Part D) premiums	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 for covered health care services before your plan begins to pay.	\$505 per year for your prescription drug (Part D) deductible \$226 per year for your medical (Part C) deductible \$1,600 per benefit period for inpatient hospital services \$1,600 per benefit period for inpatient hospital psychiatric services	

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Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
Maximum Out-of-Pocket (MOOP) Responsibility	<p>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) 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.</p>	<p>No more than \$7,550 annually</p>	<p>Your out-of-pocket limit does not include Part D prescription drug costs.</p>

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	For each benefit period ¹ , you pay: <ul style="list-style-type: none"> • \$1,600 deductible • \$0 for days 1 through 60 • \$400 for days 61 through 90 • \$800 for each of 60 lifetime reserve days • Beyond lifetime reserve days, you pay all costs 	Authorization is required.
Outpatient Hospital Coverage, including Observation Services	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. Authorization is required.

¹ A benefit period begins the day you're 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.

If you need hospital care (continued)

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Ambulatory Surgery Center (ASC)	20% coinsurance	Authorization is required.

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	
Specialist Visit	20% coinsurance per visit	
Preventive Care, such as screenings, vaccinations, and wellness visits	\$0	<p>Authorization and/or referral may be required for some preventive care services.</p> <p>Important Message About What You Pay for Vaccines Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.</p>

If you need immediate medical attention

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Emergency Care	20% coinsurance per visit up to a maximum of \$90	If you are admitted to the hospital within 24 hours, you do not have to pay the \$90 copayment.
Urgently Needed Services	20% coinsurance per visit up to a maximum of \$60	If you are admitted to the hospital within 24 hours with the same condition, you do not have to pay the \$30 copayment. Urgently needed services are only covered in the United States and its territories.

If you need medical tests

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

If you need hearing/audiological services

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Diagnostic Hearing and Balance Evaluations	\$0	
Diagnostic 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 \$500, per ear, every three (3) years for hearing aids.

If you need dental care

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
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 a year: <ul style="list-style-type: none"> • Dental Cleaning (Prophylaxis) • Dental X-Rays • Oral Exam

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)
Medicare Part B Eye Health Services	\$0	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.

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 services in a psychiatric hospital	For each benefit period ² , you pay: <ul style="list-style-type: none"> • \$1,600 deductible • \$0 for days 1 through 60 • \$400 for days 61 through 90 • \$800 for each of 60 lifetime reserve days • Beyond lifetime reserve days, you pay all costs 	Authorization is required.
Outpatient Therapy	20% coinsurance per individual or group session	Referral is required for Psychiatrist visits.

² 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 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	\$0	We cover up to 100 days in a SNF. No prior hospital stay is required.
Physical, Occupational, and/or Speech Therapy	\$0	

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	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. Authorization is required for non-emergency services.
Routine Transportation	Not covered	

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	20% coinsurance	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. Authorization is required.

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 \$505 per year. During this stage, you pay the full cost of drugs until you’ve spent \$505 on prescription drugs.	

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Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
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.	<p>During this stage, for generic drugs, you pay \$0, \$1.45, \$4.15 copayment or no more than 25% coinsurance per prescription.</p> <p>For all other drugs, you pay \$0, \$4.30, \$10.35 copayment or no more than 25% coinsurance per prescription</p>	You stay in this stage until your year-to-date total drug costs (costs paid by both you and our plan) total \$4,660. Cost sharing is based on your level of Extra Help.
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.”	During this stage, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs.	For brand-name drugs, what you pay and what the manufacturer pays will count toward your out-of-pocket spending. For generic drugs, only the amount you pay will count toward getting you out of the coverage gap. You stay in this stage until your year-to-date out-of-pocket costs reach a total of \$7,400. This amount and rules for counting costs toward this amount have been set by Medicare.

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Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
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 the greater of: 5% of the cost; or a \$4.15 copayment for generic/brand-named drugs treated as generic and a \$10.35 copayment for all other drugs.	You enter this stage when your total year-to-date out-of-pocket costs are more than \$7,400.

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	20% coinsurance per visit for up to 12 visits in 90 days for chronic low back pain. Medicare covers an additional 8 visits if improvement is demonstrated, with an annual limit of 20 visits.	Medicare-covered acupuncture is only covered under certain circumstances. Authorization is required.
Cardiac and Pulmonary Rehabilitation Services	20% coinsurance	We cover Medicare-covered services. Authorization is required.
Chiropractic Care	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	We cover Medicare-covered services. Authorization and referral are required.

If you need additional services (continued)

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

If you need additional services (continued)

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Hospice	\$0	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. Hospice is covered outside our plan. Please contact Member Services for more details.
Kidney Disease Education Services	\$0	Authorization is required.
Opioid Treatment Services	\$0	Authorization is required.
Outpatient Substance Abuse Services	20% coinsurance per individual or group session	Authorization is required.
Podiatry Services	20% coinsurance per visit	We cover Medicare-covered services.
Routine Podiatry Services*	20% coinsurance per visit	We cover up to 2 routine foot care visits every three months.
Prosthetic Devices, such as braces and artificial limbs	20% coinsurance	Authorization is required.

If you need additional services (continued)

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	Authorization is required.