2024

CENTERS PLAN FOR HEALTHY LIVING

Summary of Benefits

Centers Plan for Medicare Advantage Care (HMO)

H6988-001_CY24SB_M

2024 Summary of Benefits

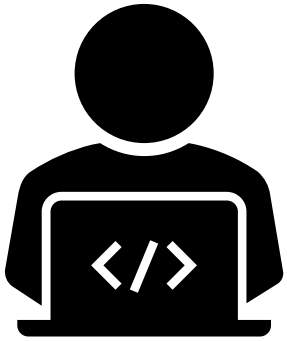
Centers Plan for Medicare Advantage Care (HMO)

January 1, 2024 - December 31, 2024

H6988, Plan 001

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

Buffalo	Hudson Valley	Long Island	New York City
Erie and Niagara Counties	Rockland County	Nassau County	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) 7 days a week, from 8 am to 8 pm.
WEBSITE	www.centersplan.com/mapd
EMAIL	MemberServices@centersplan.com
MAIL	Centers Plan for Healthy Living 75 Vanderbilt Avenue, 7th 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.

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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 Medicare Advantage Care**.
Centers Plan for Medicare Advantage Care (HMO) is an HMO with a Medicare contract. Enrollment in Centers Plan for Medicare Advantage 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/mapd.
Centers Plan for Medicare Advantage 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/mapd. Or call us and we will send you a copy of the directory.
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/mapd. 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

In order to join **Centers Plan for Medicare Advantage Care**, you must:

- Be enrolled in Medicare Parts: A (hospital insurance); B (medical insurance); and D (prescription drug insurance)
- Live in our service area: Bronx, Erie, Kings, Nassau, New York, Niagara, Queens, Richmond, and Rockland Counties
- Be lawfully present in the United States

PREMIUMS AND DEDUCTIBLES

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.	$0 for your medical (Part C) and $0 for your prescription drug (Part D) premium.	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 care services before your plan begins to pay.	$0 for your medical (Part C) deductible $395 per year for your prescription drug (Part D) deductible	Your prescription drug deductible does not apply to Tier 1 and 2 drugs or covered insulin products and most adult Part D vaccines.

Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
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) 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.	No more than $7,550 annually	Your out-of-pocket limit does not include Part D prescription drug 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	For each benefit period[1], you pay: • $305 copayment per day, for days 1 through 6 • $0 for days 7 through 90 • $0 for 60 lifetime reserve days	**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**
Ambulatory Surgery Center (ASC)	$250 copayment per visit	**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 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 copayment per visit	
Preventive Care, such as screenings, vaccinations, and wellness visits	$0	**Authorization and/or referral may be required** for some preventive care services **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.

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	$90 copayment per visit $90 per worldwide emergency care visit	If you are admitted to the hospital within 24 hours, you do not have to pay the $90 copayment. The Worldwide Coverage maximum benefit amount is $25,000.
Urgently Needed Services	$30 copayment per visit	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	$0	**Authorization is required**
Lab Services	$0	**Authorization is required**

If you need medical tests (cont.)

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
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	$0	**Authorization is required**

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)
Hearing Services (Diagnostic Hearing and Balance Evaluations)	$30 copayment per visit	
Hearing Exam (Routine)*	You pay a $0 copayment for one routine hearing exam per year.	

If you need hearing/audiological services (cont.)

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Hearing Aids*	You pay a $0 copayment for one hearing aid fitting/evaluation every three (3) years. We pay up to $1,000, per ear, for hearing aids, once every three years.	

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	$0	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.

If you need dental care (cont.)

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Preventive Dental Services*	$0	We cover each service once every six months: • Dental Cleaning (Prophylaxis) • Dental X-Rays • Fluoride Treatment • Oral Exams
Comprehensive Dental Services*	$0	Comprehensive dental services are limited to $2,000 per year. We cover: • Crowns and Posts (one every 60 months per tooth) • Dentures (one per 36 months) • Denture repairs (one per 12 months) • Endodontics, such as root canals (one per lifetime per tooth) • Extractions (one per lifetime per tooth) • Fillings (one per 24 months per tooth) • Gingivectomies (one per 36 months per quadrant)

If you need dental care (cont.)

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Comprehensive Dental Services* (cont.)		• Occlusal Guards, such as night guards (one per 12 months) • Periodontal maintenance (one per six months) • Prosthodontic Services (one every 36 months per arch); • Scaling (one every six months per quadrant)

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	We cover up to $200 per year for eyeglasses or contact lenses. Eyeglasses are limited to one pair of eyeglasses (lenses and frames) per year.
Medicare Part B Eye Health Services	$30 copayment per visit	Like Medicare Part B (medical insurance), we cover certain exams and treatments for specific conditions.

If you need vision care (cont.)

Services you may need	Costs you pay for in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
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 services in a psychiatric hospital	For each benefit period[2], you pay: • $305 copayment per day, for days 1 through 5 • $0 for days 6 through 90 • $0 for 190 lifetime reserve days • Beyond lifetime reserve days, you pay all costs.	Our plan has a 190-day lifetime limit for services in a psychiatric hospital. The limit does not apply to inpatient services provided in a psychiatric unit of a general hospital. **Authorization is required**
Outpatient Therapy	$20 copayment per individual or group session	**Referral is required for Psychiatric services**

[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	For each benefit period[3] you pay: • $0 for days 1 through 20 • $160 copayment per day, for days 21 through 100 • Days 101 and beyond, you pay all costs.	A 3-day qualifying stay in a hospital is not required. **Authorization is required**
Physical, Occupational, and/or Speech Therapy	$20 copayment per visit	**Authorization is required**

[3] 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.

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	$200 copayment	If you are admitted to the hospital within 24 hours, you do not have to pay the $200 copayment. Copayment will not exceed $200 within any 24-hour period. **Authorization is required for non-emergency services**
Routine Transportation*	You pay $0 for 6 one-way trips every three (3) months to plan-approved, health-related locations via bus, subway, van, or medical transport.	**Authorization is required**

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	You pay a 0% to 20% coinsurance for Medicare-covered Part B prescription drugs You won't pay more than $35 for a one-month supply of each Part B insulin product covered by our plan.	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 $395 per year. During this stage, you pay the full cost of drugs until you've spent $395 on prescription drugs.	Your prescription drug deductible does not apply to Tier 1 and 2 drugs or covered insulin products and most adult Part D vaccines.
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, we pay our share of the cost of your Tier 1 and 2 drugs, and you pay your share of the cost. After you have met your deductible, we pay our share of the cost of your Tier 3, 4, and 5 drugs, and you pay your share of the cost. You pay no more than $35 per month supply of each covered insulin product.	You stay in this stage until your year-to-date total drug costs (costs paid by both you and our plan) total $5,030.

Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
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-out-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 $8,000. This amount and rules for counting costs toward this amount have been set by Medicare.

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, 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.

PRESCRIPTION DRUG TIERS AND YOUR COSTS

If you need prescription drugs during the Initial Coverage Phase (Stage 2), after you have paid your deductible

Prescription Drug Tier	Your cost for a one (1)-month supply at a retail pharmacy (in-network pharmacy)	Your cost for a three (3)-month supply at a retail pharmacy (in-network pharmacy)	Your cost for a three (3)-month supply through our mail-order pharmacy (MedImpact Direct)
Tier 1: Preferred Generic Drugs	$0 You pay $0 per month supply of each covered insulin product on this tier.	$0	$0
Tier 2: Generic Drugs	$15 copayment You pay no more than $35 per month supply of each covered insulin product on this tier.	$45 copayment	$37.50 copayment

Prescription Drug Tier	**Your cost for a one (1)-month supply at a retail pharmacy (in-network pharmacy)**	**Your cost for a three (3)-month supply at a retail pharmacy (in-network pharmacy)**	**Your cost for a three (3)-month supply through our mail-order pharmacy (MedImpact Direct)**
Tier 3: Preferred Brand Drugs	$47 copayment You pay no more than $35 per month supply of each covered insulin product on this tier.	$141 copayment	$117.50 copayment
Tier 4: Non-Preferred Brand Name Drugs	$100 copayment You pay no more than $35 per month supply of each covered insulin product on this tier.	$300 copayment	$250 copayment
Tier 5: Specialty Tier	25% coinsurance	Three (3)-month supply is not available for this Tier.	Mail order is not available for this Tier.

Limitation, exceptions, and other information:

- If you reside in a long-term care facility, you receive one (1)-month supplies of drugs and pay the same as at a retail pharmacy.
- You may get drugs from an out-of-network pharmacy, but you may pay more than you pay at an in-network pharmacy.

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 for visits 13 through 20**
Cardiac and Pulmonary Rehabilitation Services	$20 copayment per visit for Medicare-covered Cardiac Rehabilitation Services	We cover Medicare-covered services. **Authorization is required**

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)
Cardiac and Pulmonary Rehabilitation Services (cont.)	$15 copayment for Medicare-covered Pulmonary Rehabilitation Services	
Chiropractic Care	$15 copayment 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**
Diabetes Self-Management Training	$0	**Authorization is required**
Diabetes Supplies and Services	$0	We cover Medicare-covered diabetic supplies and therapeutic shoes or inserts. Quantity limits apply to non-Part D diabetic supplies: • If you use insulin, we cover up to 150 test strips and 150 lancets every 30 days.

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 Supplies and Services (cont.)		• 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.
Dialysis	20% coinsurance	**Authorization is required**
Durable Medical Equipment (DME)	20% coinsurance	**Authorization is required**
Home Health Care	$0	**Authorization is required**
Hospice	$0	**Hospice is covered outside our plan.** 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	**Authorization is required**

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)
Opioid Treatment Services	$0	**Authorization is required**
Outpatient Substance Abuse Services	$30 copayment per individual or group session	**Authorization is required**
Over-the-Counter (OTC) Items*	$0	You may purchase up to $100 every three months of eligible OTC items using your OTC debit card. Unused amounts cannot be carried over from quarter to quarter. Please visit www.mybenefitscenter.com to see our list of covered OTC items.
Podiatry Services	$20 copayment per visit	We cover Medicare-covered services. **Authorization and referral are required**

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)
Prosthetic Devices, such as braces and artificial limbs	20% coinsurance	**Authorization is required**
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	$0	**Authorization is required**
Worldwide Emergency Coverage*	$90 copayment per visit	The $90 copayment is waived if you are admitted to the hospital. The Worldwide Coverage maximum benefit amount is $25,000.

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 1-877-940-9330 (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 1-877-940-9330 (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 1-877-940-9330 (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 1-877-940-9330 (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：1-877-940-9330（TTY：711）。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。

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.
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 1-877-940-9330 (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, 7th 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

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, from 8 am to 8 pm
MemberServices@centersplan.com
www.centersplan.com/mapd