2024

CENTERS PLAN FOR HEALTHY LIVING

Summary of Benefits

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

H6988-003_CY24SB_M

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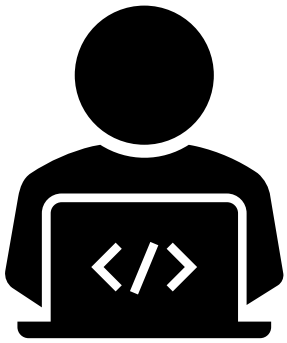
Centers Plan for Nursing Home Care (HMO I-SNP)

January 1, 2024 - December 31, 2024

H6988, Plan 003

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

Buffalo	Hudson Valley	Long Island	New York City
Erie and Niagara Counties	Rockland and Westchester Counties	Nassau and Suffolk Counties	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/isnp
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 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.
Centers Plan for Nursing Home 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/isnp. 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/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.

Our plan 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, **and** 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.

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 $48.70 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.

Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
Deductible	Deductible is the amount you pay during a coverage period for covered health care services before your plan begins to pay.	$240 per year for your medical (Part B) deductible $1,632 per benefit period for inpatient hospital services $1,632 per benefit period for inpatient hospital psychiatric services $545 per year for your prescription drug (Part D) deductible	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.

Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
Maximum Out-of-Pocket (MOOP) Responsibility	Out-of-Pocket Limit 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 $8,850 annually	Your out-of-pocket limit does not include amounts you pay for your plan premium or 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: • $1, 632 deductible • $0 for days 1 through 60 • $408 for days 61 through 90 • $816 for each of 60 lifetime reserve days • Beyond lifetime reserve days, you pay all costs	**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 (cont.)

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
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)	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	**Authorization and/or referral may be required** for some preventive care services.

If you need to see a doctor (cont.)

Services you may need	Costs you pay for using in-network providers	Limitations, exceptions, and other benefit information (rules about benefits)
Preventive Care, such as screenings, vaccinations, and wellness visits (cont.)		**Important Message About What You Pay for Vaccines –** 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.

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, your copayment is waived. Emergency care services are not covered outside of the United States and its territories except under limited circumstances.
Urgently Needed Services	20% coinsurance per visit up to a maximum of $55	If you are admitted to the hospital within 24 hours with the same condition, your coinsurance is waived. 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	**Authorization is required**
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)
Hearing Services (Diagnostic Hearing and Balance Evaluations)	$0	

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)
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

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 below once a year: • Dental Cleaning (Prophylaxis) • Dental X-Rays • Oral Exams

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 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: • $1,632 deductible • $0 for days 1 through 60 • $408 for days 61 through 90	**Authorization is required**

[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 mental health services (cont.)

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 (cont.)	• $816 for each of 60 lifetime reserve days • Beyond lifetime reserve days, you pay all costs • 20% coinsurance for mental health services you get from doctors and other health care providers while you're a hospital inpatient	
Outpatient Therapy	20% coinsurance per individual or group session	**Referral required for Psychiatric services**

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. A 3-day qualifying stay in a hospital is not 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*	You pay $0 for 4 one-way trips every month 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 $545 per year. During this stage, you pay the full cost of drugs until you've spent $545 on prescription drugs.	The deductible does not apply to 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, 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.	You stay in this stage until your year-to-date total drug costs (costs paid by both you and our plan) total $5,030. Cost sharing is based on your level of Extra Help.

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."	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.

Health Insurance Term	Definition	Your costs	Limitations, exceptions, and other information
Coverage Gap (Stage 3) (cont.)			This amount and rules for counting costs toward this amount have been set by Medicare.
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.

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% 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 (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	20% coinsurance	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 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	20% coinsurance	
Durable Medical Equipment (DME)	20% coinsurance	**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)
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**
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 for Medicare-covered podiatry services	
	20% coinsurance for up to 2 routine foot care* visits every three months.	

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**

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/isnp