2024

CENTERS PLAN FOR HEALTHY LIVING

Summary of Benefits

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

H6988-004_CY24SB_M

Introduction

This document is a brief summary of the benefits and services covered by Centers Plan for Medicaid Advantage Plus. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of Centers Plan for Medicaid Advantage Plus. Key terms and their definitions appear in alphabetical order in the last chapter of the *Evidence of Coverage*.

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A. Disclaimers

This is a summary of health services covered by Centers Plan for Medicaid Advantage Plus for 2024. This is only a summary. Read the *Evidence of Coverage* for the full list of benefits. If you don't have an *Evidence of Coverage (EOC)*, call Centers Plan for Medicaid Advantage Plus Member Services at the number at the bottom of this page to get one. The *Evidence of Coverage* is also on our website at www.centersplan.com/map.

- 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 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 Medicaid Advantage Plus.
- This information is not a complete description of benefits. For more information, call 1-833-274-5627. TTY users, please call 711.
- Centers Plan for Medicaid Advantage Plus is a plan that covers Medicare and Medicaid services for those who live in the service area, have both Medicare Parts A and B, have full benefit Medicaid, and need Medicaid home care and/or other long-term care services.

If you have questions, call Centers Plan for Medicaid Advantage Plus Member Services at 1-833-274-5627, TTY 711, seven days a week, from 8 am to 8 pm. The call is free. **For more information**, visit www.centersplan.com/map.

- This plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and State government program that helps with medical costs for certain people with limited incomes and resources.)
- To be eligible for our plan, you:
    - Must be eligible for Medicare **and** full Medicaid benefits;
    - Must be capable, at the time of enrollment, of returning to or remaining in your current home and community without jeopardy to health and safety, based upon criteria provided by New York State Department of Health;
    - Must be eligible for nursing home level of care (as of the time of enrollment);
    - Must require care management and be expected to need at least one of the following Community based Long-term Care services for more than 120 days from the effective date of enrollment:
        - Nursing services in the home;
        - Therapies in the home;
        - Home health aide services;
        - Personal care services in the home;
        - Adult day health care;
        - Private duty nursing; or

    - Consumer Directed Personal Assistance Services (CDPAS)

  - Must be 18 years of age or older;
  - Must reside in the plan's service area; and
  - Are determined eligible for long-term care services by the plan or an entity designated by the New York State Department of Health using the current NYS eligibility tool.

- Under our plan you can get your Medicare and most of your Medicaid services in one health plan. A Centers Plan for Medicaid Advantage Plus care manager will help manage your health care needs.
- The food, produce, and utilities benefits mentioned in this document are Special Supplemental Benefits for the Chronically Ill (SSBCI) and not all members will qualify.
- 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 services.
- 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.

- For more information about **Medicare**, you can read the *Medicare & You* handbook. Every year in the fall, this booklet 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 booklet, you can access it online at the Medicare website (www.medicare.gov) or request a copy 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.
- You can get this document for free in other formats, such as large print, braille, or audio. Call 1-833-274-5627 (TTY: 711), seven days a week, from 8 am to 8 pm. The call is free.
- Puede obtener este documento de manera gratuita en otros formatos, como impresión con letra grande, braille o audio. Llama al 1-833-274-5627 (TTY: 711), los siete días de la semana, de 8:00 a.m. a 8:00 p.m. La llamada es gratuita.
- We want to make sure you have access to plan materials in your preferred language. So, when you call, we'll ask you for your preferred language and whether you want your materials in that language. We might also reach out to you once more a year to make sure the information we have on file about your preference is correct. Of course, you are always able to make changes to your preference by:

- Speaking with a live representative at 1-833-274-5627 (TTY:711), seven days a week, from 8 am to 8 pm.
- Sending a letter to us at:

  Centers Plan for Medicaid Advantage Plus
  Attn: Member Services
  75 Vanderbilt Avenue
  Staten Island, NY 10304

- Sending an email to us at: MemberServices@centersplan.com.

B. Frequently asked questions

The following table lists frequently asked questions.

Frequently Asked Questions (FAQ)	Answers
What is a Medicaid Advantage Plus (MAP/HMO D-SNP) plan?	Our MAP plan is a Health Maintenance Organization (HMO) aligned with a Dual Eligible (Medicaid and Medicare) Special Needs Plan (D-SNP). Our plan combines your Medicaid home care and long-term care services and your Medicare services. It combines your doctors, hospital, pharmacies, home care, nursing home care, behavioral health care (mental health and substance use/addiction services), and other health care providers into one coordinated health care system. It also has care managers to help you manage all of your providers and services. They all work together to provide the care you need. Our MAP plan is called Centers Plan for Medicaid Advantage Plus.

Frequently Asked Questions (FAQ)	Answers
Will I get the same Medicare and Medicaid benefits in Centers Plan for Medicaid Advantage Plus that I get now?	If you are coming to Centers Plan for Medicaid Advantage Plus from Original Medicare or another Medicare plan, you may get benefits or services differently. You will get almost all of your covered Medicare and Medicaid benefits directly from our plan. When you enroll in Centers Plan for Medicaid Advantage Plus, you and your Care Team will work together to develop an individualized Plan of Care to address your health and support needs, reflecting your personal preferences and goals. If you are taking any Medicare Part D prescription drugs that our plan does not normally cover, you can get a temporary supply, and we will help you to transition to another drug or get an exception for us to cover your drug if medically necessary.

Frequently Asked Questions (FAQ)	Answers
Can I use the same health care providers I use now?	That is often the case. **If your providers (including doctors, therapists, pharmacies, and other health care providers) work with Centers Plan for Medicaid Advantage Plus and have a contract with us, you can keep going to them.** • Providers with an agreement with us are "in-network." **You must use the providers in our plan's network.** • If you need urgent or emergency care or behavioral health crisis services or out-of-area dialysis services, you can use providers outside of Centers Plan for Medicaid Advantage Plus's network. You may also use out-of- network providers when the plan authorizes the use of out-of-network providers. To find out if your providers are in the plan's network, call Member Services at the number listed at the bottom of this page or read Centers Plan for Medicaid Advantage Plus's *Provider and Pharmacy Directories*.

Frequently Asked Questions (FAQ)	Answers
Can I use the same health care providers I use now? (cont.)	You can also visit our website at www.centersplan.com/map for the most current listing. If Centers Plan for Medicaid Advantage Plus is new for you, we will work with you to develop an individualized plan of care (ICP) to address your needs. You can keep using the providers you use now for 90 days or until your ICP is completed. Further, members who enroll on or after January 1, 2023, can continue to use their same behavioral health providers for up to 24 months as part of a continuous episode of care. “Continuous Behavioral Health Episode of Care” means a course of ambulatory behavioral health treatment, other than ambulatory detoxification and withdrawal services, which began prior to the effective date of the behavioral health benefit inclusion into MAP in the geographic service area in which services had been provided to an enrollee at least twice during the six months preceding January 1, 2023 by the same provider for the treatment of the same or related behavioral health condition.

Frequently Asked Questions (FAQ)	Answers
What is a Care Manager?	A Care Manager is your main contact person at our plan. This person helps to manage all of your providers and services and make sure you get what you need. Members may have a Care Manager who works for the Plan as well as a specialized Health Home/Health Home Plus Care Manager (refer to Section D. Benefits covered outside of Centers Plan for Medicaid Advantage Plus on 61).
What are Managed Long Term Services and Supports (MLTSS)?	Managed Long Term Services and Supports (MLTSS) are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Often these services are provided at your home or in your community, but they could also be provided in a nursing home or hospital when necessary. MLTSS is available to members who meet certain clinical and financial requirements.

Frequently Asked Questions (FAQ)	Answers
What happens if I need a service but no one in Centers Plan for Medicaid Advantage Plus's network can provide it?	Most services will be provided by our network providers. If you need a service that cannot be provided within our network, such as due to shortage of staff with necessary expertise and/or availability to provide services, Centers Plan for Medicaid Advantage Plus will cover services provided by an out-of-network provider.
Where is Centers Plan for Medicaid Advantage Plus available?	The service area for this plan includes: Bronx, Erie*, Kings (Brooklyn), Nassau, New York (Manhattan), Niagara*, Queens, Richmond (Staten Island), Rockland, Suffolk*, and Westchester*. You must live in one of these areas to join the plan. **Coming soon*

Frequently Asked Questions (FAQ)	Answers
What is prior authorization?	Prior authorization means that you must get approval from Centers Plan for Medicaid Advantage Plus before our plan will cover a specific service, item, or drug or out-of-network provider. Centers Plan for Medicaid Advantage Plus may not cover the service, item, or drug if you don't get prior approval. If you need urgent or emergency care or behavioral health crisis services or out-of-area dialysis services, you don't need to get approval first. Centers Plan for Medicaid Advantage Plus can provide you with a list of services or procedures that require you to get prior authorization from Centers Plan for Medicaid Advantage Plus before the service is provided. Refer to Chapter 3, of the *Evidence of Coverage* to learn more about prior authorization. Refer to the Benefits Chart in Chapter 4 of the *Evidence of Coverage* to learn which services require a prior authorization.

Frequently Asked Questions (FAQ)	Answers
What is a referral?	A referral means that your primary care provider (PCP) must give you written approval before you can use specialists or other providers in the plan's network. If you don't get approval, Centers Plan for Medicaid Advantage Plus may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. Centers Plan for Medicaid Advantage Plus can provide you with a list of services that require you to get a referral from your PCP before the service is provided. For more information on when a referral is needed, call Member Services at the numbers listed at the bottom of this page or refer to Chapter 3, of the *Evidence of Coverage.*
Do I pay a monthly amount (also called a premium) under Centers Plan for Medicaid Advantage Plus?	No. You will not pay any monthly premiums to Centers Plan for Medicaid Advantage Plus for your health coverage. Additionally, Medicaid will pay your Medicare Part B premium for you.

Frequently Asked Questions (FAQ)	Answers
Do I pay a deductible as a member of Centers Plan for Medicaid Advantage Plus?	No. You do not pay deductibles in our plan.
What is the maximum out-of-pocket amount that I will pay for medical services as a member of Centers Plan for Medicaid Advantage Plus?	There is no cost sharing (copays or deductibles) for medical services in Centers Plan for Medicaid Advantage Plus, so your annual out-of-pocket costs will be $0.
Do I have a coverage gap for drugs?	No. Because you have Medicaid you will not have a coverage gap stage for your drugs.

C. Overview of services

The following table is a quick overview of what services you may need and rules about the benefits.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care (This service is continued on the next page)	Inpatient hospital care	$0	Except in an emergency, your health care provider must tell the plan of your hospital admission. **Authorization is required**
	Outpatient hospital services (including outpatient treatment by a doctor or a surgeon)	$0	**Authorization is required**

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care (continued)	Ambulatory surgical center (ASC) services	$0	**Authorization is required**
You want to use an outpatient health care provider (This service is continued on the next page)	Doctor visits (including visits to Primary Care Providers and specialists)	$0	**A referral and/or authorization may be required for certain Specialist care (e.g., podiatry and psychiatric services)** Please see the *Evidence of Coverage* for more information
	Visits to treat an injury or illness	$0	**A referral and/or authorization may be required for certain Specialist care (e.g., podiatry and psychiatric services)** Please see the *Evidence of Coverage* for more information

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want to use a health care provider (continued)	Preventive care (care to keep you from getting sick, such as flu shots and other immunizations)	$0	**A referral and/or authorization may be required for certain Specialist care (e.g., podiatry and psychiatric services)** **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.
	Wellness visits, such as a physical	$0	
	"Welcome to Medicare" preventive visit (one time only)	$0	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need emergency care (This service is continued on the next page)	Emergency room services, including mental health emergencies at Comprehensive Psychiatric Emergency Programs (CPEPs)	$0	You may use any emergency room or CPEP if you reasonably believe you need emergency care. You do not need prior authorization and you do not have to be in-network. Emergency room services are NOT covered outside of the U.S. and its territories except under limited circumstances. Contact the plan for details.
	Urgent care	$0	Urgent care is not emergency care. You do not need prior authorization and

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need emergency care (continued)	Urgent care (continued)		you do not have to be in-network. Urgent care is NOT covered outside the U.S. and its territories except under limited circumstances. Contact the plan for details.
You need medical tests	Lab tests, such as blood work	$0	**Authorization is required**
	X-rays or other pictures, such as CAT scans	$0	**Authorization is required**
	Screenings, such as tests to check for cancer	$0	**Authorization is required**

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hearing/ auditory services	Hearing screenings (including routine hearing exams)	$0	We cover: ❖ One annual routine hearing exam ❖ One hearing aid fitting/ evaluation every three years
	Hearing aids (as well as fittings and associated accessories and supplies)	$0	We pay up to $1,000, per ear, every three years for hearing aids.
You need dental care (This service is continued on the next page)	Dental services (including, but not limited to, routine exams and cleanings, X-rays, fillings, crowns, extractions, dentures, and endodontic and periodontal care)	$0	We cover the following **Preventive Dental Services:** ❖ Cleaning (one every six months) ❖ Dental X-Ray(s) (one every six months)

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care (continued)	Dental services (continued)		❖ Fluoride treatment (one every six months) ❖ Oral exam (one every six months) We cover the following **Comprehensive Dental Services**, which are limited to $2,000 per year**:** ❖ Crown and Posts (one every 60 months per tooth) ❖ Dentures (one every 36 months) ❖ Denture Repairs (one every 12 months) ❖ Endodontics, such as root canals (one

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care (continued)	Dental services (continued)		per lifetime per tooth) ❖ Extractions (one per lifetime per tooth) ❖ Filling (one every 24 months per tooth) ❖ Gingivectomies (one every 36 months per quadrant) ❖ Occlusal guards, such as night guards (one every 12 months) ❖ Periodontal maintenance (one every six months) ❖ Prosthodontics (i.e., restoring/ replacing missing or damaged teeth) services (one

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care (continued)	Dental services (continued)		every 36 months per arch) ❖ Scaling (one every six months per quadrant)
You need eye care (This service is continued on the next page)	Vision services (including annual eye exams)	$0	We cover: ❖ One routine eye exam per year
	Glasses or contact lenses	$0	We cover: ❖ Up to $200 every year for contacts or eyeglasses • Eyeglasses are limited to one pair (lenses and frame) per year. ❖ One pair of eyeglasses or contacts after each cataract surgery that implants an intraocular lens.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need eye care (continued)	Other vision care (including diagnosis and treatment for diseases and conditions of the eye)	$0	
You have a mental health condition (This service is continued on the next page)	Inpatient mental health care (long-term mental health services, including inpatient services in a psychiatric hospital, general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), State Operated Addiction Treatment	$0	All members are covered by the plan for acute inpatient hospitalization in a general hospital, regardless of the admitting diagnosis or treatment. Except in an emergency, your health care provider must tell the plan of your hospital admission.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	Center's (ATC), Inpatient addition rehabilitation, Inpatient Medically Supervised Detox, or critical access hospital)		**Authorization is required**
	Adult outpatient mental health care • Continuing Day Treatment (CDT) • Partial hospitalization	$0	**Authorization is required for CDT and ACT services**

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	Adult outpatient rehabilitative mental health care • Assertive Community Treatment (ACT) • Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) • Personalized Recovery Oriented Services (PROS)	$0	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	Adult outpatient rehabilitative mental health and addiction services for members who meet clinical requirements These are also known as Community Oriented Recovery and Empowerment (CORE) services. CORE services: • Psychosocial Rehabilitation (PSR) • Community Psychiatric Supports and Treatment (CPST)	$0	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	• Empowerment services – peer supports • Family Support and Training (FST)		
	Adult mental health crisis services • Comprehensive Psychiatric Emergency Program (CPEP) • Mobile Crisis and Telephonic Crisis Services • Crisis Residential Programs	$0	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	Outpatient mental health care (including, but not limited to, clinical counseling and therapy, peer support, psychosocial rehabilitation, medication management, family psychoeducation, and intensive outpatient models of care) (**Note:** This is not a complete list of the plan's expanded outpatient mental health services. Call Member	$0	Services may be provided by any OMH licensed, designated, or approved provider agency, or a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, Independent Practitioner Network (IPN) Psychiatrist, Psychologist or Advanced Practice Nurse (APN), or other qualified mental health care professional as allowed under applicable state laws.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	Services at the numbers listed at the bottom of this page or read the *Evidence of Coverage* for more information.)		**A referral is required for Psychiatric services.**
You are having a mental health or substance use crisis (This service is continued on the next page)	Mobile Crisis services (assessment by telephone or mobile crisis team response); short-term residential crisis stabilization (for mental health crises)	$0	Any approved mobile crisis or licensed crisis residence provider in New York State.
	CORE Services (which are person-centered,	$0	CORE services are available to members who meet certain

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition or a substance use disorder (continued)	recovery-oriented mobile behavioral health supports. CORE Services build skills and self-efficacy that promote and facilitate community participation and independence). (**Note:** For more information about CORE Services and to determine whether you are eligible for them, call Member Services at the numbers listed at the bottom of this page or read the *Evidence of Coverage*.)		clinical requirements. Anyone can refer or self-refer to CORE Services.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a substance use disorder (This service is continued on the next page)	Inpatient and outpatient substance use disorder treatment services (including, but not limited to, detoxification and withdrawal management, short-term residential services, residential treatment center services, and methadone Medication Assisted Treatment) (**Note:** This is not a complete list of the plan's	$0	**Authorization is required**

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a substance use disorder (continued)	expanded substance use disorder services. Call Member Services at the numbers listed at the bottom of this page or read the *Evidence of Coverage* for more information.)		
You need a place to live with people available to help you (This service is continued on the next page)	Skilled nursing care	$0	We cover: ❖ Up to 100 days in a SNF (no prior hospital stay is required.) **Authorization is required**
	Nursing home	$0	**Authorization is required.**

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need a place to live with people available to help you (continued)	Custodial care (long-term care in a Nursing Facility)	$0	Services are covered for those who meet nursing facility level of care and whose rehabilitation goals have been met or discontinued with no plan to discharge to the community within 180 days of admission. **Authorization is required**
You need therapy after a stroke or accident	Occupational, physical, or speech therapy (outpatient or in-home)	$0	There may be limits on physical therapy, occupational therapy, and speech therapy services. If so, there may be exceptions to these limits. **Authorization is required**

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help getting to health services (This service is continued on the next page)	Ambulance services	$0	Ambulance services must be medically necessary. You do not need prior authorization for emergency ambulance services, which do not have to be in-network. **Authorization is required for non-emergency Ambulance Services.**
	Emergency transportation	$0	
	Transportation to health care services	$0	We cover: ❖ Transportation essential for an enrollee to obtain

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help getting to health services (continued)	Transportation to health care services (continued)		necessary medical care and services under the plan's benefits or Medicaid fee-for-service are covered. Includes ambulette, invalid coach, taxicab, livery, public transportation, or other means appropriate to the enrollee's medical condition and a transportation attendant to accompany the enrollee, if necessary.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (This service is continued on the next page)	Medicare Part B prescription drugs (including those given by your provider in their office, some oral anti-cancer drugs, and some drugs used with certain medical equipment)	$0	Read the *Evidence of Coverage* for more information on these drugs. **Authorization is required**
	Medicare Part D prescription drugs	$0 for a 30-day supply.	There may be limitations on the types of drugs covered. Refer to Centers Plan for Medicaid Advantage Plus's *List of Covered Drugs* at www.centersplan.com/map for more information.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Medicare Part D prescription drugs (continued)		**Important Message About What You Pay for Vaccines** – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs* (Formulary). Our plan covers most Part D vaccines at no cost to you. Centers Plan for Medicaid Advantage Plus may require you to first try one drug to treat your condition before it will cover

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Medicare Part D prescription drugs (continued)		another drug for that condition. Some drugs have quantity limits. **Your provider must get prior authorization from Centers Plan for Medicaid Advantage Plus for certain drugs.** You must use certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Medicare Part D prescription drugs (continued)		network. These drugs are listed on the plan's website, *List of Covered Drugs* (Drug List), and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.medicare.gov/plan-compare. Extended-day supplies of some drugs are available at retail and/or mail order pharmacy locations. Cost-sharing amount for these extended-day supplies is the same as for a one-month supply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Medicare Part D prescription drugs (continued)		Drugs marked with "NDS" (non-extended day supply) in the Drug List are limited to a one-month supply or less.
	Over-the-counter (OTC) drugs	$0	We cover: ❖ Up to $290 every month of eligible OTC items on an OTC debit card. Unused amounts **cannot** be carried over from month to month. Please visit www.mybenefitscenter.com, to see our list of covered items.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Over-the-counter (OTC) drugs (continued)		**Please note:** The $290 monthly OTC benefit allowance is a combined (i.e., OTC and SSBCI benefits) monthly allowance which can also be used towards your food & produce and utilities benefits (*if you qualify*). 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 benefits, the $290 monthly allowance can be used on OTC items only.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Diabetes medications	$0	
You need foot care	Podiatry services (including routine exams)	$0	We cover: ❖ Medicare-covered podiatry services, including care for medical conditions affecting lower limbs ❖ Up to four routine foot care visits per year **Authorization is required**
	Orthotic services	$0	**Authorization is required**

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need durable medical equipment (DME) or supplies	Wheelchairs, nebulizers, crutches, roll about knee walkers, walkers, and oxygen equipment and supplies, for example (**Note:** This is not a complete list of covered DME or supplies. Call Member Services at the numbers listed at the bottom of this page or read the *Evidence of Coverage* for more information.)	$0	**Authorization is required**

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need interpreter services	Spoken language interpreter	$0	
	Sign language interpreter	$0	
Other covered services (This service is continued on the next page)	Acupuncture	$0	We cover: ❖ Up to 20 routine acupuncture treatments per year
	Acupuncture (Medicare-covered)	$0	We cover: ❖ Up to 12 visits in 90 days for chronic low back pain (This is Medicare-covered acupuncture which is only covered under certain circumstances) ❖ An additional eight sessions will be

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	Acupuncture (Medicare-covered) (contined)		covered for Medicare beneficiaries demonstrating an improvement. Contact Member Services or see the *Evidence of Coverage* at www.centersplan.com/map for details. **Authorization is required for visits 13-20**
	Plan Care coordination	$0	
	Chiropractic services	$0	We cover: ❖ Medicare-covered Chiropractic Services (manual-manipulation of the spine to correct a

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	Chiropractic services (continued)		subluxation, which is when one or more of the bones of your spine moves out of position) **Authorization and Referral are required**
	Diabetic supplies	$0	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 do not use insulin**, we cover up to 100 test strips and 100 lancets every 90 days. ❖ Diabetes supplies and services are

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	Diabetic supplies (continued)		limited to a specific manufacturer, Abbott Diabetes Care.
	Early Periodic Screening and Treatment (EPSDT)	$0	The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for members 18 to 21. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	Family planning	$0	Family planning services furnished by out-of-network providers are covered directly by Medicaid fee-for-service.
	Home Health Care Services	$0	**Authorization is required**
	Hospice care	$0	Hospice is a service covered by Medicare fee-for-service.
	Mammograms	$0	
	Managed Long Term Services and Supports (MLTSS) (including, but not limited to, assisted living services; cognitive, speech, occupational, and	$0	MLTSS provides services for members that need the level of care typically provided in a Nursing Facility, and allows them to get necessary care in a residential or community setting.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	physical therapy; chore services; home-delivered meals; residential modifications (such as the installation of ramps or grab bars); social adult day care; and non-medical transportation)		MLTSS is available to all members; specific service authorization, including amount, is indicated in the member's individualized approved Plan of Care. **Authorization is required**
	Medical day care (including preventive, diagnostic, therapeutic, and rehabilitative services under medical and nursing supervision in an ambulatory care setting)	$0	Medical day care is provided to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living. **Authorization is required**

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	Personal Care Assistance (PCA) (assistance with daily activities such as bathing, dressing, using the bathroom, shopping, cooking, including health-related tasks performed by a qualified individual in a member's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a member's written plan of care)	$0	**Authorization is required**

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	Personal Emergency Response Services (PERS)	$0	We cover: ❖ Electronic devices that enable individuals to secure help in a physical, emotional, or environmental emergency **Authorization is required**
	Prosthetic services	$0	**Authorization is required**
	Services to help manage your disease	$0	**Authorization is required**

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	Special Supplemental Benefits for the Chronically Ill (SSBCI): Blood Pressure Monitor Benefit	$0	Eligible members can receive a blood pressure monitor once a year, based on medical necessity. To qualify for this SSBCI benefit, members must: ❖ Be an active participant 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:

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)			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; end-stage renal disease (ESRD); HIV/AIDS;

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)			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.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	Special Supplemental Benefits for the Chronically Ill (SSBCI): Food & Produce, and Utilities Benefits	$0	We cover up to $290 every month of the following, purchased on your OTC card: ❖ Eligible food items, including but not limited to canned foods, frozen foods and produce at participating retailers ❖ Utilities (electric, gas, heating oil, water, landline phone, and internet) Unused amounts **cannot** be carried over from month to month. **Please note:** The $290 monthly food & produce and utilities benefit (*if you qualify*)

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)			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 and produce and utilities benefits, the $290 monthly allowance can be used on OTC items only. To qualify for this SSBCI benefit, members must: ❖ Be an active participant in our

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)			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;

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)			end-stage liver disease; 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.

The above summary of benefits is provided for informational purposes only. For more information about your benefits, you can read Centers Plan for Medicaid Advantage Plus's *Evidence of Coverage*. If you have questions, you can also call our plan's Member Services at the numbers listed at the bottom of this page.

D. Benefits covered outside of Centers Plan for Medicaid Advantage Plus

This is not a complete list. Call Member Services at the numbers listed at the bottom of this page to find out about other services not covered by Centers Plan for Medicaid Advantage Plus but available through Medicaid fee-for-service.

Other services covered directly by Medicaid fee-for-service	**Your costs**
CSS (Community Support Services)	$0
Health Home (HH) and Health Home Plus (HH+) Care Management services	$0
Certified Community Behavioral Health Clinics (CCBHC)	$0
Crisis Intervention Services for Youth ages 18-20	$0

E. Services that Centers Plan for Medicaid Advantage Plus, Medicare, and Medicaid do not cover

The following services are not covered by our plan. This is not a complete list. Call Member at the numbers listed at the bottom of this page to find out about other excluded services.

Services Centers Plan for Medicaid Advantage Plus, Medicare, and Medicaid do not cover	
Conversion or reparative therapy	Personal and Comfort items
Cosmetic surgery if not medically necessary	Services of a provider that is not part of the plan, unless the plan sends you to that provider
Radial keratotomy, LASIK surgery or other low vision aids	Reversal of sterilization procedures

F. Your rights and responsibilities as a member of the plan

As a member of Centers Plan for Medicaid Advantage Plus, you have certain rights concerning your health care. You also have certain responsibilities to the health care providers who are taking care of you. Regardless of your health condition, you cannot be refused medically necessary treatment. You can use these rights without losing your health care services. We will tell you about your rights at least once a year. For more information on your rights, read the *Evidence of Coverage.*

Your rights include, but are not limited to, the following:

- **You have a right to respect, fairness, and dignity.** This includes the right to:
  - Get covered services without concern about race, ethnicity, national origin, color, religion, creed, sex (including sex stereotypes and gender identity), age, health status, mental, physical, or sensory disability, sexual orientation, genetic information, ability to pay, or ability to speak English. No health care provider should engage in any practice, with respect to any member that constitutes unlawful discrimination under any state or federal law or regulation.
  - Ask for and get information in other formats (for example, large print, braille, audio) free of charge
  - Be free from any form of physical restraint or seclusion
  - Not be billed by network providers

- Have your questions and concerns answered completely and courteously
- Apply your rights freely without any negative effect on the way Centers Plan for Medicaid Advantage Plus or your provider treats you

- **You have the right to get information about your health care.** This includes information on treatment and your treatment options, regardless of cost or benefit coverage. This information should be in a format and language you can understand. These rights include getting information on:
  - Centers Plan for Medicaid Advantage Plus
  - Description of the services we cover
  - How to get services
  - How much services will cost you
  - Names of health care providers and Care Managers
  - Your rights and responsibilities
- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  - Choose a primary care provider (PCP) and change your PCP at any time during the year. You can call 1-833-274-5627 (TTY:711) if you want to change your PCP.
  - Use a women's health care provider without a referral
  - Get your covered services and drugs quickly
  - Know about all treatment options, no matter what they cost or whether they are covered

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? **If you have questions**, call Centers Plan for Medicaid Advantage Plus Member Services at 1-833-274-5627, TTY 711, seven days a week, from 8 am to 8 pm. The call is free. **For more information**, visit www.centersplan.com/map.

- Refuse treatment as far as the law allows, even if your health care provider advises against it
- Stop taking medicine, even if your health care provider advises against it
- Ask for a second opinion about any health care that your PCP or your Care Team advises you to have. Our plan will pay for the cost of your second opinion visit.
- Make your health care wishes known in an advance directive

- **You have the right to timely access to care that does not have any communication or physical access barriers.** This includes the right to:
  - Get timely medical care
  - Get in and out of a health care provider's office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act
  - Have interpreters to help with communication with your doctors, other providers, and your health plan. Call 1-833-274-5627 (TTY:711) if you need help with this service
  - Have your *Evidence of Coverage* and any printed materials from our plan translated into your primary language, and/or have these materials read out loud to you if you have trouble seeing or reading. Oral interpretation services will be made available upon request and free of charge.
  - Be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation

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? **If you have questions**, call Centers Plan for Medicaid Advantage Plus Member Services at 1-833-274-5627, TTY 711, seven days a week, from 8 am to 8 pm. The call is free. **For more information**, visit www.centersplan.com/map.

- **You have the right to emergency and urgent care when you need it**. This means you have the right to:
  - Get emergency and urgent care services, 24 hours a day, 7 days a week, without prior approval
  - Use an out-of-network urgent or emergency care provider, when necessary
- **You have a right to confidentiality and privacy.** This includes the right to:
  - Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
  - Have your personal health information kept private. No personal health information will be released to anyone without your consent, unless required by law.
  - Have privacy during treatment
- **You have the right to make complaints about your covered services or care.** This includes the right to:
  - Access an easy process to voice your concerns, and to expect follow-up by Centers Plan for Medicaid Advantage Plus
  - File a complaint or grievance against us or our providers. You also have the right to appeal certain decisions made by us or our providers
  - Ask for a State Appeal (State Fair Hearing)
  - Get a detailed reason why services were denied

Your responsibilities include, but are not limited to, the following:

- **You have a responsibility to treat others with respect, fairness, and dignity.** You should:
  - Treat your health care providers with dignity and respect
  - Keep appointments, be on time, and call in advance if you're going to be late or have to cancel
- **You have the responsibility to give information about you and your health.** You should:
  - Tell your health care provider your health complaints clearly and provide as much information as possible
  - Tell your health care provider about yourself and your health history
  - Tell your health care provider that you are a Centers Plan for Medicaid Advantage Plus member
  - Talk to your PCP, Care Manager, or other appropriate person about seeking the services of a specialist before you go to a hospital (except in cases of emergency)
  - Tell your PCP, Care Manager, or other appropriate person within 24 hours of any emergency or out-of-network treatment
  - Notify Centers Plan for Medicaid Advantage Plus Member Services if there are any changes in your personal information, such as your address or phone number

- **You have the responsibility to make decisions about your care, including refusing treatment.** You should:
  - Learn about your health problems and any recommended treatment, and consider the treatment before it's performed
  - Partner with your Care Team and work out treatment plans and goals together
  - Follow the instructions and plans for care that you and your health care provider have agreed to, and remember that refusing treatment recommended by your health care provider might harm your health
- **You have the responsibility to obtain your services from Centers Plan for Medicaid Advantage Plus.** You should:
  - Get all your health care from Centers Plan for Medicaid Advantage Plus, except in cases of emergency, urgent care, behavioral health crisis services, out-of-area dialysis services, or family planning services, unless our plan provides a prior authorization for out-of-network care
  - Not allow anyone else to use your Centers Plan for Medicaid Advantage Plus Member ID Card to obtain healthcare services
  - Notify Centers Plan for Medicaid Advantage Plus when you believe that someone has purposely misused our plan's benefits or services

For more information about your rights, you can read Centers Plan for Medicaid Advantage Plus's *Evidence of Coverage*. If you have questions, you can also call Centers Plan for Medicaid Advantage

Plus Member Services at the numbers listed at the bottom of this page.

G. How to file a complaint or appeal a denied service

If you have a complaint or think our plan should cover something we denied, call Centers Plan for Medicaid Advantage Plus at 1-833-274-5627 (TTY:711). You can file a complaint or appeal our decision.

For questions about complaints and appeals, you can read Chapter 9 of our plan's *Evidence of Coverage*. You can also call Centers Plan for Medicaid Advantage Plus Member Services at the numbers listed at the bottom of this page.

For complaints and appeals about covered services, you can contact Member Services at 1-833-274-5627 (TTY users, please call 711), seven days a week, from 8 am to 8 pm; or you can write to:

Centers Plan for Healthy Living, LLC
75 Vanderbilt Avenue
Staten Island, NY 10304
Attn: Grievances and Appeals

H. What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, contact us.

- Call us at Centers Plan for Medicaid Advantage Plus Member Services. Phone numbers are the numbers listed at the bottom of this page.
- Call Centers Plan for Medicaid Advantage Plus's Fraud Hot Line at 1-855-699-5046.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- Or, call the New York State Medicaid Fraud Hotline 1–877–87 FRAUD

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 1-833-274-5627 (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.

If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, call Centers Plan for Medicaid Advantage Plus Member Services:

1-833-274-5627
Calls to this number are free. We are open seven days a week, from 8 am to 8 pm.
Member Services also has free language interpreter services available for non-English speakers.

711: This number is only for people who have difficulties with hearing or speaking.
Calls to this number are free. We are open seven days a week, from 8 am to 8 pm.

Si tiene preguntas generales o preguntas sobre nuestro plan, servicios, área de servicio, facturación o tarjetas de identificación de miembro, llame a Servicios al Miembro de Centers Plan for Medicaid Advantage Plus:

1-833-274-5627
Las llamadas a este número son gratuitas. Estamos abiertos los 7 días de la semana, de 8:00 a.m. a 8:00 p.m.
Los Servicios al Miembro también cuentan con servicios de interpretación gratuitos, disponibles para las personas que no hablan inglés.

Los usuarios de TTY deben llamar al 711: Este número es solo para personas con problemas de audición o del habla.
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If you have questions about your health:

- Call your primary care provider (PCP). Follow your PCP's instructions for getting care when the office is closed.
- If your PCP's office is closed, you can also call a nurse care manager. A nurse will listen to your problem and tell you how to get care. (Example: go to urgent care/emergency room).

The number for the nurse care manager is:

1-833-274-5627; TTY users call 711

Calls to this number are free. We are open seven days a week, from 8 am to 8 pm.

Centers Plan for Medicaid Advantage Plus also has free language interpreter services available for non-English speakers.

If you need immediate behavioral health care, call the Centers Plan for Medicaid Advantage Plus Behavioral Health Crisis Line:

1-888-600-8241, TTY users call 711

Calls to this number are free. We are open 24 hours a day, seven days a week. Centers Plan for Medicaid Advantage Plus also has free language interpreter services available for non-English speakers.

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