CarePartners of Connecticut
MEDICARE ADVANTAGE

2024 Summary of Benefits

CarePartners of Connecticut HMO Plan

This *Summary of Benefits* covers the plan in the following counties in Connecticut: **Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, and Windham.**

CareAdvantage Preferred (HMO)

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please visit **www.carepartnersct.com/documents** to view the *Evidence of Coverage.* You can also request a printed copy by calling Member Services at 1-888-341-1507 (TTY: 711), 8:00 a.m. – 8:00 p.m., 7 days a week from October 1 to March 31 and Monday-Friday from April 1 to September 30.

Effective January 1, 2024–December 31, 2024

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Summary of Benefits

January 1, 2024–December 31, 2024

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as CarePartners of Connecticut (HMO)).

Tips for comparing your Medicare choices

This *Summary of Benefits* booklet gives you a summary of what CarePartners of Connecticut (HMO) covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder at **www.medicare.gov**.
- If you want to know more about the 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**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Things to Know About CarePartners of Connecticut (HMO)

Who can join?

To join CarePartners of Connecticut (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

The service area for the plan described in this document includes the following counties in Connecticut: Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, and Windham.

Which doctors, hospitals, and pharmacies can I use?

CarePartners of Connecticut (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's *Provider and Pharmacy Directory* at our website (**www.carepartnersct.com**).

What do we cover?

We cover everything that Original Medicare covers—and more.

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay less in our plan than you would in Original Medicare. For others, you may pay more.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

CarePartners of Connecticut CareAdvantage Preferred covers Part D drugs, as well as enhanced coverage of certain drugs such as select erectile dysfunction (ED) drugs, vitamins and minerals, and cough/cold products. In addition, the plan cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **www.carepartnersct.com**.

How will I determine my drug costs for CarePartners of Connecticut CareAdvantage Preferred?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. The amount you pay also depends on whether you fill your prescription at a preferred pharmacy or a non-preferred pharmacy. Later in this document, we discuss the benefit stages: Initial Coverage, the Coverage Gap, and Catastrophic Coverage.

This document is available in other formats such as Braille and large print.

Monthly Plan Premium	CareAdvantage Preferred
	$0 per month
What You Should Know	In addition, you must keep paying your Medicare Part B premium.
Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$4,900
What You Should Know	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the limit on out-of-pocket costs, we will pay the full cost of your covered hospital and medical services for the rest of the year. Please note that you will still need to pay your monthly premiums (and cost-sharing for your Part D prescription drugs if applicable).

Inpatient and Outpatient Care and Services	CareAdvantage Preferred
Inpatient Hospital Care	
Inpatient hospital care	$395 copay per day for days 1 through 5; $0 copay for day 6 and beyond
What You Should Know	Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.
Outpatient Hospital Care	
Outpatient hospital services	$370 copay per day
Outpatient surgery (services provided at hospital outpatient facilities)	Colonoscopies: $0 copay; Other services: $370 copay per day
Ambulatory surgical center (ASC) services	Colonoscopies: $0 copay; Other services: $270 copay per day
What You Should Know	Prior authorization may be required.
Doctor Visits	
Primary care physician	$0 copay per visit
Specialist	$45 copay per visit
What You Should Know	There is no copay for an annual physical exam with your PCP. Office visit copay applies for surgery services furnished in the physician's office. Before you receive services from out-of-network specialists, you must obtain a referral from your PCP.
Preventive Care	$0 copay per visit
What You Should Know	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$90 copay per visit
What You Should Know	If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. Your plan includes worldwide coverage for emergency care.

Inpatient and Outpatient Care and Services	CareAdvantage Preferred
Urgently needed services	$45 copay per visit
What You Should Know	Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Copayment is not waived if admitted as an inpatient within 24 hours. Your plan includes worldwide coverage for urgently needed care.
Diagnostic Services/Labs/Imaging	
Diagnostic radiology services (such as MRIs, CT scans)	$60 copay per day for ultrasound; $250 copay per day for all other services
Diagnostic tests and procedures	$30 copay per day
Lab services	$0 copay
Outpatient X-rays	$30 copay per day
What You Should Know	Diagnostic tests and procedures, lab services, and outpatient X-rays performed and billed as part of an office visit or urgent care visit will not pull a separate copay in addition to the applicable office visit or urgent care copay. Prior authorization may be required.
Hearing Services	
Exam to diagnose and treat hearing and balance issues	$45 copay per visit
Routine hearing exam (up to 1 every year)	$0 copay per visit
Hearing aids	Standard level: $250 copay per hearing aid. Superior level: $475 copay per hearing aid. Advanced level: $650 copay per hearing aid. Advanced Plus level: $850 copay per hearing aid. Premier level: $1,150 copay per hearing aid.
What You Should Know	Before you receive a diagnostic hearing exam from an out-of-network specialist, you must obtain a referral from your PCP. You must purchase hearing aids through Hearing Care Solutions to receive the hearing aid benefit. Up to 2 hearing aids per year, 1 hearing aid per ear. Hearing aid fitting is provided by Hearing Care Solutions at no cost.
Dental	
Limited Medicare-covered dental services	$45 copay per visit
What You Should Know	Limited Medicare-covered dental services do not include preventive dental services such as cleaning, routine dental exams, and dental X-rays.

Inpatient and Outpatient Care and Services	CareAdvantage Preferred
Embedded dental benefit	• $3,000 calendar year maximum. • $0 copay for preventive services such as routine cleanings, oral exams, fluoride treatments, and bitewing x-rays; 20% coinsurance for basic services such as fillings and x-rays other than bitewing images; and 50% coinsurance for major services such as extractions, dentures, bridges, crowns, and implants. • $0 deductible. • No waiting period.
What You Should Know	The plan is administered by Dominion Dental Services, Inc., which operates under the trade name Dominion National. Benefit limits apply. A member may choose to receive treatment from a non-participating dentist. Cost shares for out-of-network benefits, if applicable, are based on procedure classification. Benefits are calculated using a Maximum Allowable Charge (MAC). Members are responsible for any amount charged which exceeds the MAC per procedure. Billing arrangements are between the member and the non-participating dentist. If a member receives treatment from a non-participating dentist, the member may be required to make payment in full at the time of service, and then submit a claim to the plan for benefit payment. Please refer to your Evidence of Coverage for more information.
Vision Services	
Routine eye exam (up to 1 every year)	$15 copay per visit
Exam to diagnose and treat diseases and conditions of the eye	$45 copay per visit
Annual glaucoma screening	$0 copay per visit
Annual diabetic retinopathy screening	$0 copay per visit
Annual eyewear benefit	Up to $150 allowance per calendar year
What You Should Know	You must use a participating vision care provider (EyeMed Vision Care) to receive the covered Routine Eye Exam benefit. You must purchase your glasses, frames, prescription lenses, and/or contacts from a participating vision provider (EyeMed Vision Care) to receive the $150 allowance. Otherwise, the benefit will be limited to $90 per year. A referral is required from your PCP before you receive a diagnostic eye exam from an out-of-network provider.
Mental Health Services	
Inpatient visit	$395 copay per day for days 1 through 5; $0 copay for day 6 and beyond
Outpatient group or individual therapy visit	$20 copay per visit
What You Should Know	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital. Before you receive outpatient group or individual therapy visits from an out-of-network provider, you must obtain a referral from your PCP.

Inpatient and Outpatient Care and Services	CareAdvantage Preferred
Skilled Nursing Facility (SNF)	
Skilled nursing facility (SNF)	$0 copay per day for days 1 through 20; $178 copay per day for days 21 through 59; $0 copay per day for days 60 through 100
What You Should Know	Our plan covers up to 100 days in a SNF per benefit period. No prior hospital stay is required.
Physical Therapy	
Occupational therapy	$30 copay per visit
Physical therapy and speech and language therapy	$30 copay per visit
What You Should Know	Before you receive occupational therapy, physical therapy, or speech and language therapy services from an out-of-network provider, you must obtain a referral from your PCP.
Ambulance	
Ambulance	$300 copay per one-way trip
What You Should Know	Prior authorization may be required for non-emergency transportation.
Transportation	
Transportation	Not covered
Medicare Part B Drugs	
Medicare Part B drugs	For Part B chemotherapy drugs: You pay up to 20% of the cost; Insulin: $35 copay per 30-day supply; Other Part B drugs: You pay up to 20% of the cost.
What You Should Know	Your actual coinsurance rate for non-insulin Medicare Part B drugs each quarter will vary based on adjustment for applicable rebates supplied by Medicare. Your coinsurance will not exceed 20% for all non-insulin Medicare Part B prescription drugs. Part B drugs may be subject to Step Therapy requirements. Prior authorization may be required.

Prescription Drug Benefits: Initial Coverage	CareAdvantage Preferred		
Note: Tier 1 and Tier 2 drugs include enhanced coverage of certain drugs such as select erectile dysfunction (ED) drugs, and vitamins.	There is no deductible. You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.		
Retail Cost Sharing—Preferred Pharmacy			
Tier	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Generic)	$0	$0	$0
Tier 3 (Preferred Brand)	$47 (Insulin: $35)	$94 (Insulin: $70)	$141 (Insulin: $105)
Tier 4 (Non-Preferred Drug)	$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)
Tier 5 (Specialty Tier)	33% of the cost	N/A	N/A
Tier 6 (Vaccines)	$0	N/A	N/A
Retail Cost Sharing—Non-Preferred Pharmacy			
Tier	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$10	$20	$30
Tier 2 (Generic)	$15	$30	$45
Tier 3 (Preferred Brand)	$47 (Insulin: $35)	$94 (Insulin: $70)	$141 (Insulin: $105)
Tier 4 (Non-Preferred Drug)	$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)
Tier 5 (Specialty Tier)	33% of the cost	N/A	N/A
Tier 6 (Vaccines)	$0	N/A	N/A

Prescription Drug Benefits: Initial Coverage	CareAdvantage Preferred		
Mail Order Cost Sharing			
Tier	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Generic)	$0	$0	$0
Tier 3 (Preferred Brand)	$47 (Insulin: $35)	$94 (Insulin: $70)	$94 (Insulin: $70)
Tier 4 (Non-Preferred Drug)	$100 (Insulin: $35)	$200 (Insulin: $70)	$200 (Insulin: $70)
Tier 5 (Specialty Tier)	33% of the cost	N/A	N/A
Tier 6 (Vaccines)	N/A	N/A	N/A
	If you reside in a long-term care facility, you pay the same as at a preferred retail pharmacy. You may get drugs from an out-of-network pharmacy, but you may pay more than you pay at an in-network pharmacy. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.		

Prescription Drug Benefits: Coverage Gap	CareAdvantage Preferred
	Most Medicare drug plans have a coverage gap (also called the "Donut Hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay nothing for covered Tier 6 vaccine drugs obtained through a retail pharmacy, 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs. The table below shows your cost share for insulin during this stage. You stay in this stage until your costs total $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Insulin			
	30-day supply	60-day supply	90-day supply
Retail Cost Sharing	$35	$70	$105
Mail order cost sharing	$35	$70	$70

Prescription Drug Benefits: Catastrophic Coverage	CareAdvantage Preferred
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay nothing for covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

Additional Benefits	CareAdvantage Preferred
Acupuncture	
Acupuncture services	$20 copay per visit
What You Should Know	Medicare covers up to 12 visits in 90 days for members with chronic low back pain. 8 additional visits covered for those demonstrating an improvement. No more than 20 visits administered annually. Before you receive services from an out-of-network provider, you must obtain a referral from your PCP. The plan will reimburse services rendered and billed directly by a licensed acupuncturist. Additional acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. See additional details under "Wellness Programs."
Chiropractic Care	
Manual manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)	$20 copay per visit
Initial evaluation (once per year)	$20 copay per visit
What You Should Know	Before you receive services from an out-of-network provider, you must obtain a referral from your PCP.
Foot Care (podiatry services)	
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	$45 copay per visit
What You Should Know	Before you receive services from an out-of-network provider, you must obtain a referral from your PCP.
Home Health Services	
Home health agency care	$0 copay
Home infusion therapy	$0 copay
What You Should Know	Prior authorization may be required for home infusion therapy services.
Hospice	
	Benefit provided by Medicare
What You Should Know	You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
Medical Equipment/Supplies	
Durable medical equipment (e.g., wheelchairs, oxygen)	20% of the cost
Prosthetic devices (e.g., braces, artificial limbs, etc.)	20% of the cost

Additional Benefits	CareAdvantage Preferred
What You Should Know	Additional items covered by the plan: bathroom safety equipment for members who have a functional impairment when having the item will improve safety: • Raised toilet seat: 1 per member every five years • Bathroom grab bars: 2 per member every five years • Tub seat: 1 per member every five years The following additional items are covered by the plan: • Gradient compression stockings or surgical stockings: up to 2 pairs every 6 months • Mastectomy sleeves for members with upper limb lymphedema: up to 2 pairs every 6 months Prior authorization may be required.
Wig allowance (for hair loss due to cancer treatment)	$500 per year
Diabetes services and supplies	$0 copay
What You Should Know	Includes diabetes monitoring supplies, diabetes self-management training, and therapeutic shoes or inserts. Copay may apply if you receive other medical services during the same office visit. Referral is required for out-of-network diabetes self-management training. Coverage for blood glucose monitors and blood glucose tests strips are limited to the OneTouch products manufactured by LifeScan, Inc. Please note that there is no preferred brand for lancets. Covered therapeutic Continuous Glucose Monitors (CGMs) include Dexcom and FreeStyle Libre products that are considered Durable Medical Equipment (DME) by Medicare. CGMs require prior authorization. Diabetic testing supplies, including test strips, lancets, glucose meters, and CGMs are also covered at participating retail or mail-order pharmacies.
Outpatient Substance Abuse	
Group or individual therapy visit	$20 copay per visit
What You Should Know	Before you receive outpatient group or individual therapy visits from an out-of-network provider, you must obtain a referral from your PCP.
Renal Dialysis	
	20% of the cost
Telehealth/Telemedicine Services	
	Medicare-covered services plus additional telehealth services including PCP services, specialist services, and more. You pay $0 for e-visits, virtual check-ins, and remote patient monitoring with a PCP or Specialist. For all other telehealth visits, the copay is the same as the corresponding in-person visit copay.

Additional Benefits	CareAdvantage Preferred
Wellness Programs	
Over-the-counter (OTC) for Medicare items	$67 per calendar quarter
What You Should Know	No rollover of unused calendar quarter balance. Items available at participating retailers and plan approved online stores.
Weight Management program	The plan provides a $150 annual Weight Management reimbursement towards program fees for weight loss programs such as WeightWatchers® or a hospital-based weight loss program.
What You Should Know	Does not include meals or other program items, such as scales.
Wellness Allowance	The plan provides a $175 annual Wellness reimbursement toward health club memberships, nutritional counseling, acupuncture, or fitness classes like Pilates, tai chi, or aerobics, and wellness programs, including memory fitness activities.
SilverSneakers®	SilverSneakers encourages physical activity by offering access to classes, exercise equipment, and other amenities. Members receive a basic fitness membership and access to over 14,000 participating locations. SilverSneakers offers different ways to get the activity you need to stay healthy.

Value Added Items and Services	
As a member of a CarePartners of Connecticut HMO plan, you get exclusive discounts in addition to your plan benefits to help you lead a healthy lifestyle. Save on everything from health products to weight management, and a variety of wellness programs. This list of member discounts is effective January 1, 2024, and may change during the year. Please see our website at **www.carepartnersct.com/wellness/discounts-extras** for additional information.	
Fitness, Nutrition, and Weight Management	**Well Balanced Meal Delivery Program** Get a 15% discount on home-delivered meals through Independent Living Systems. Home-delivered meals offer a convenient and affordable way to recover from an illness, a surgical procedure, or to manage a chronic condition. **Nutritional Counseling** Get a 25% discount on visits with registered dieticians and licensed nutritionists. **The Dinner Daily** The Dinner Daily makes healthy, delicious dinners easy and affordable by providing you with weekly dinner plans customized for your food preferences, dietary needs, and the specials at your local grocery store! Receive 25% on any Dinner Daily subscription. Plus, your first two weeks are free to make it easy to try.
Independent Living	**Be Safer at Home** Receive a discounted rate on the installation and monthly fees of a Personal Emergency Response System (PERS). A PERS unit allows you to live the independent lifestyle you want by providing a resource that is always there to respond to emergency calls. BSAH has several options to meet your lifestyle and budget needs including; Landline, Cellular, Mobile, Mobile GPS, and Fall Detection. **LifeCycle Transitions** Save 20% on a variety of services that help members with chronic health problems stay well at home or transition to a new location. **Hartford HealthCare Independence at Home** Members receive a free in-home care plan development session and a $100 credit to use towards services with Hartford HealthCare Independence at Home. If living independently becomes difficult due to age or disability, caregivers from Hartford HealthCare Independence at Home can help you or your loved ones maintain your life in the comfort of home. Members also receive a 10% discount on the medication dispenser service. ($100 credit does not apply to this service). Members get a discount by showing their member ID at time of purchase.
Health and Wellness Discounts	**Massage Therapy** Get a 25% discount on the usual and customary fee, or pay $15 per 15 minutes of massage therapy, whichever is less. **Acupuncture** Receive a 25% discount on the usual and customary fee. **Laser Vision Correction** Get 15% off the retail price, or 5% off the promotional price of LASIK and PRK laser vision correction. **Ompractice** With Ompractice, you can access live, online yoga and meditation classes led by an instructor to practice yoga from the comfort and privacy of your own home. Ompractice utilizes two-way video, so you can participate in group classes and receive feedback and support from your teacher. Sign up for Ompractice for $129.00 for an annual subscription (40% off the regular monthly subscription rate). Additionally, CareAdvantage Preferred members, who have an annual wellness benefit, may use their Annual Wellness Allowance to cover the cost of membership.

CarePartners of Connecticut
MEDICARE ADVANTAGE

Multi-language Interpreter Services

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 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-341-1507 (HMO)/1-866-632-0060 (PPO)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-341-1507 (HMO)/1-866-632-0060 (PPO)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-341-1507 (HMO)/1-866-632-0060 (PPO)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-888-341-1507 (HMO)/1-866-632-0060 (PPO)** . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Ta usługa jest bezpłatna.

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Y0151_2023_17_C

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(Expires 12/31/25)

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