CarePartners of Connecticut
MEDICARE ADVANTAGE

2026 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, 2026–December 31, 2026

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Summary of Benefits

January 1, 2026–December 31, 2026

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 select erectile dysfunction (ED) drugs. In addition, the plan covers 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 that occur after you meet your deductible: Initial Coverage 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 (for Part D prescription drugs)	$450 per year for your Tier 3, Tier 4, and Tier 5 drugs.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$6,750
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 6; $0 copay for day 7 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	$350 copay per day
Outpatient surgery (services provided at hospital outpatient facilities)	Colonoscopies: $0 copay; Other services: $350 copay per day
Ambulatory surgical center (ASC) services	Colonoscopies: $0 copay; Other services: $250 copay per day
What You Should Know	Prior authorization may be required.
Doctor Visits	
Primary care physician	$0 copay per visit
Specialist	$55 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. A referral may be required from your PCP before you receive services from out-of-network specialists. Your PCP will provide this referral if needed.
Preventive Care (Medicare preventive services)	$0 copay per visit
What You Should Know	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$130 copay per visit
What You Should Know	If you are held for observation or admitted to the hospital within one day for the same condition, the emergency care copay will be waived and the applicable observation or inpatient cost share will apply. Your plan includes worldwide coverage for emergency care.

Inpatient and Outpatient Care and Services	CareAdvantage Preferred
Urgently needed services	$50 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 one day. 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; $200 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	A referral may be required from your PCP before you receive diagnostic hearing exam from out-of-network providers. Your PCP will provide this referral if needed. You must purchase hearing aids through TruHearing, Inc. to receive the hearing aid benefit. Up to 2 hearing aids per year, 1 hearing aid per ear. Hearing aid fitting is provided by TruHearing, Inc. 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 cleanings, routine dental exams, and dental X-rays. Prior authorization may be required. A referral may be required from your PCP before you receive dental services from out-of-network providers. Your PCP will provide this referral if needed.
Embedded supplemental dental benefit	• $2,000 calendar year maximum. • $0 copay for preventive services such as routine cleanings, oral exams, fluoride treatments, and bitewing X-rays; 20% coinsurance (after deductible) for basic services such as fillings and X-rays other than bitewing images; and 50% coinsurance (after deductible) for major services such as extractions, dentures, bridges, and crowns. • $100 deductible on basic and major services. • No waiting period.

Inpatient and Outpatient Care and Services	CareAdvantage Preferred
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)	$0 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 if received as part of an annual routine xam. $45 copay per visit if received as part of a service that addresses other medical conditions.
Annual eyewear benefit	Up to $300 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 can purchase your glasses, frames, prescription lenses, and/or contacts including upgrades either from a participating vision provider (EyeMed Vision care) or a non-participating provider to receive the $300 allowance. If you use a non-participating provider, you would need to pay out of pocket and submit for reimbursement. Only one purchase is allowed per calendar year up to the benefit amount; any unused amount after the single purchase will expire and cannot be applied toward another purchase during the calendar year. A referral may be required from your PCP before you receive a diagnostic eye exam from out-of-network providers. Your PCP will provide this referral if needed.
Mental Health Services	
Inpatient care visit	$395 copay per day for days 1 through 5; $0 copay for day 6 and beyond
Outpatient group or individual therapy visit	$40 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. A referral may be required from your PCP before you receive outpatient group or individual therapy services from out-of-network providers. Your PCP will provide this referral if needed.
Skilled Nursing Facility (SNF)	
Skilled nursing facility (SNF)	$0 copay per day for days 1 through 20; $218 copay per day for days 21 through 100
What You Should Know	Prior authorization may be required. Our plan covers up to 100 days in an SNF per benefit period. No prior hospital stay is required.

Inpatient and Outpatient Care and Services	CareAdvantage Preferred
Physical Therapy	
Occupational therapy	$25 copay per visit
Physical therapy and speech and language therapy	$25 copay per visit
What You Should Know	Prior authorization may be required. A referral may be required from your PCP before you receive these services from out-of-network providers. Your PCP will provide this referral if needed.
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 may 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: Deductible (for Part D prescription drugs)	CareAdvantage Preferred
Deductible	$450 per year for your Tier 3, Tier 4, and Tier 5 drugs.

Prescription Drug Benefits: Initial Coverage	CareAdvantage Preferred		
Note: Tier 1 and Tier 2 drugs include enhanced coverage of select erectile dysfunction (ED) drugs.	After you pay your yearly deductible of $450 for Tier 3, Tier 4, and Tier 5 drugs, you pay the Tier 3, Tier 4, or Tier 5 copays listed below until your total yearly drug costs reach $2,100. 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)	$2	$4	$6
Tier 3 (Preferred Brand)	20% of the cost (Insulin: $35)	20% of the cost (Insulin: $70)	20% of the cost (Insulin: $105)
Tier 4 (Non-Preferred Drug)	25% of the cost (Insulin: $35)	25% of the cost (Insulin: $70)	25% of the cost (Insulin: $105)
Tier 5 (Specialty Tier)	26% 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)	$5	$10	$15
Tier 2 (Generic)	$12	$24	$36
Tier 3 (Preferred Brand)	20% of the cost (Insulin: $35)	20% of the cost (Insulin: $70)	20% of the cost (Insulin: $105)
Tier 4 (Non-Preferred Drug)	25% of the cost (Insulin: $35)	25% of the cost (Insulin: $70)	25% of the cost (Insulin: $105)
Tier 5 (Specialty Tier)	26% 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)	$2	$4	$4
Tier 3 (Preferred Brand)	20% of the cost (Insulin: $35)	20% of the cost (Insulin: $70)	20% of the cost (Insulin: $70)
Tier 4 (Non-Preferred Drug)	25% of the cost (Insulin: $35)	25% of the cost (Insulin: $70)	25% of the cost (Insulin: $70)
Tier 5 (Specialty Tier)	26% 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 Tier 1, Tier 2, and Tier 6 drugs, and you pay your share of the cost. After you have met your annual $450 Tier 3, Tier 4, and Tier 5 deductible, the plan pays its share of the cost of your Tier 3, Tier 4, and Tier 5 drugs, and you pay your share.		

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 $2,100, 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. A referral may be required from your PCP before you receive these services from out-of-network providers. Your PCP will provide this referral if needed. 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)	$15 copay per visit
Initial evaluation (once per year)	$15 copay per visit
What You Should Know	Prior authorization may be required. A referral may be required from your PCP before you receive these services from out-of-network providers. Your PCP will provide this referral if needed.
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	A referral may be required from your PCP before you receive these services from out-of-network providers. Your PCP will provide this referral if needed.
Home Health Services	
Home health agency care	$0 copay
Home infusion therapy	$0 copay
What You Should Know	Prior authorization may be required. A referral may be required from your PCP before you receive home health agency care services from out-of-network providers. Your PCP will provide this referral if needed.
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. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.
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 Prior authorization may be required.
Wig allowance (for hair loss due to cancer treatment)	$500 per year
Diabetes services and supplies	$0 copay for Accu-Chek products manufactured by Roche Diabetes Care, Inc., Continuous Glucose Monitors (CGMs), and Diabetes self-management training. 20% of the cost for therapeutic shoes or inserts and non-Accu-Chek products;
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. A referral may be required from your PCP before you receive diabetes self-management training services from out-of-network providers. Your PCP will provide this referral if needed. Coverage for blood glucose monitors, blood glucose tests strips, and control systems are limited to the Accu-Chek products manufactured by Roche Diabetes Care, Inc. Please note that there is no preferred brand for lancets. Coverage for therapeutic Continuous Glucose Monitors (CGMs) is limited to Dexcom and FreeStyle Libre products that are considered Durable Medical Equipment (DME) by Medicare. Diabetic testing supplies, including test strips, lancets, glucose meters, and CGMs are also covered at participating retail or mail-order pharmacies.
Outpatient Substance Use Disorder Services	
Group or individual therapy visit	$40 copay per visit
What You Should Know	A referral may be required from your PCP before you receive these services from out-of-network providers. Your PCP will provide this referral if needed.
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) credit for Medicare-approved health-related items	$50 per calendar quarter
What You Should Know	Quarterly OTC credit is for the purchase of Medicare-approved OTC items from participating retailers and plan-approved online stores. Unused balance at the end of a calendar quarter does not roll over. Under certain circumstances, items may be covered under your Medicare Part B or Part D benefit.
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.
CarePerks: Wellness Allowance	The plan provides a $500 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. Additional programs and items include alternative therapies, massage therapy, home fitness equipment, and fitness tracking devices and heart rate monitors (limit of one per year).
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, 2026, and may change during the year. Discounts and services included as value added items and services are not plan benefits and are not subject to the Medicare appeals process. 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. **Mom's Meals** Mom's Meals Affinity Program provides members with access to nutritious, home-delivered meals. • Shipping included on all orders • Meals last in the refrigerator for 14 days from delivery and are ready to heat, eat and enjoy in minutes • Members conveniently order online or by phone

Value Added Items and Services	
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 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. **Hearing Aid Discount** Discount is available on a wide selection of hearing aid choices from major manufacturers up to 63% below retail. • 3-year supply of batteries at no charge • 1-year in-office servicing at no charge • 3-year comprehensive warranty, including loss and damage • 60-day hearing aid evaluation period • Complete hearing aid evaluation at no charge • No interest financing available for 12 months for qualified applicants

CarePartners of Connecticut MEDICARE ADVANTAGE

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) (TTY: 711) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) (TTY: 711) o hable con su proveedor.

Português (Portuguese) ATENÇÃO: Se fala Português, estão disponíveis para si serviços gratuitos de assistência linguística. Estão também disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) (TTY - Dispositivo das telecomunicações para surdos: 711) ou fale com o seu prestador.

中文 (**Simplified Chinese**) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-888-341-1507 (HMO)/1-866-632-0060 (PPO)（文本电话：711）或咨询您的服务提供商。

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) (TTY: 711) oswa pale avèk founisè w la.

Việt (Vietnamese) LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) (TTY: 711) или обратитесь к своему поставщику услуг.

(Arabic)العربية تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 711 (1507-341-888-1 (PPO) 0060-632-866-1/(HMO)) أو تحدث إلى مقدم الخدمة.

Français (French) ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) (TTY: 711) ou parlez à votre fournisseur.

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-888-341-1507 (HMO)/1-866-632-0060 (PPO) (tty: 711) o parla con il tuo fornitore.

한국어 **(Korean)** 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-888-341-1507 (HMO)/1-866-632-0060 (PPO)(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) (TTY: 711) ή απευθυνθείτε στον πάροχό σας.

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हिंदी **(Hindi)**न दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

SHQIP (Albanian) VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) (TTY: 711) o makipag-usap sa iyong provider.

Questions

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