CAREPARTNERS OF CONNECTICUT HMO PLANS | 2019

Summary of Benefits

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

CareAdvantage Preferred

CareAdvantage Prime

CareAdvantage Premier

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 call Customer Service to request the "Evidence of Coverage", or visit carepartnersct.com.

Effective January 1, 2019–December 31, 2019
H5273_2019_124_M

CarePartners of Connecticut

SUMMARY OF BENEFITS
January 1, 2019 – December 31, 2019

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).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what CarePartners of Connecticut 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 on http://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 http://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

Hours of operation

- From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.
- From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

CarePartners of Connecticut phone numbers and website

- If you are a member of this plan, call toll-free 1-888-341-1507 (TTY: 711).
- If you are not a member of this plan, call toll-free 1-844-267-2321 (TTY: 711).
- Our website: carepartnersct.com

Who can join?

To join CarePartners of Connecticut, 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 plans described in this document includes the following counties in Connecticut: Hartford, Litchfield, New Haven, New London, Tolland, and Windham.

Which doctors, hospitals, and pharmacies can I use?

CarePartners of Connecticut 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 (carepartnersct.com). Or, call us and we will send you a copy of the Provider and Pharmacy Directory.

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

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 more in our plan than you would in Original Medicare. For others, you may pay less.
- 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, CarePartners of Connecticut CareAdvantage Prime, and CarePartners of Connecticut CareAdvantage Premier cover Part D drugs. In addition, all plans 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, carepartnersct.com.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs for CarePartners of Connecticut CareAdvantage Preferred, CarePartners of Connecticut CareAdvantage Prime, and CarePartners of Connecticut CareAdvantage Premier?

Our plan groups each medication into one of five "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. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
Monthly Plan Premium			
	$0 per month	$29.00 per month	$89.00 per month
What You Should Know	In addition, you must keep paying your Medicare Part B premium.		
Deductible			
Part D prescription drug deductible *(except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible)*			
	$200 per year	$150 per year	This plan does not have a deductible.
Medical deductible			
	$0	$0	$0
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*			
	$5,900 annually	$4,900 annually	$3,700 annually
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			
Inpatient Hospital			
	• $425 copay per day for days 1 through 4 • You pay nothing per day for days 5 and beyond	• $375 copay per day for days 1 through 4 • You pay nothing per day for days 5 and beyond	• $250 copay per day for days 1 through 5 • You pay nothing per day for days 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 Surgery			
Ambulatory surgical center	$300 copay per visit	$275 copay per visit	$250 copay per visit
Outpatient hospital	$300 copay per visit	$275 copay per visit	$250 copay per visit
What You Should Know	Before you receive services, you must obtain a referral from your PCP. Prior authorization may be required.		

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
INPATIENT AND OUTPATIENT CARE AND SERVICES			
Doctor Visits			
Primary care provider	$0 copay per visit	$0 copay per visit	$0 copay per visit
Specialist	$45 copay per visit	$40 copay per visit	$30 copay per visit
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.		
Preventive Care			
	You pay nothing		
What You Should Know	Any additional preventive services approved by Medicare during the contract year will be covered.		
Emergency Care			
	$90 copay per visit	$90 copay per visit	$90 copay per visit
What You Should Know	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Your plan includes worldwide coverage for emergency care.		
Urgently Needed Services			
	$0-45 copay per visit, depending on the service	$0-40 copay per visit, depending on the service	$0-30 copay per visit, depending on the service
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. Your plan includes worldwide coverage for urgently needed care.		
Diagnostic Services/Labs/Imaging			
Diagnostic radiology services *(such as MRIs, CT scans)*	$250 copay per day	$250 copay per day	$150 copay per day
Diagnostic tests and procedures	$20 per day per provider	$15 per day per provider	$10 per day per provider
Lab services	$5 per day per provider	$5 per day per provider	$5 per day per provider
Outpatient X-rays	$30 per day per provider	$20 per day per provider	$15 per day per provider
What You Should Know	Prior authorization may be required.		

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
INPATIENT AND OUTPATIENT CARE AND SERVICES			
Hearing Services			
Exam to diagnose and treat hearing and balance issues	$45 copay per visit	$40 copay per visit	$30 copay per visit
Routine hearing exam *(up to 1 every year)*	$45 copay per visit	$40 copay per visit	$30 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	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	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
What You Should Know	Before you receive a diagnostic hearing exam from a specialist, you must obtain a referral from your PCP. You must see a Hearing Care Solutions provider to receive the Hearing Aid benefit. Up to 2 hearing aids per year, 1 hearing aid per ear.		
Dental			
Limited Medicare-covered dental services	$45 copay per visit	$40 copay per visit	$30 copay per visit
Preventive dental allowance	$250 per year	$250 per year	$250 per year
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. Prior authorization may be required for Medicare-covered dental services. The preventive dental allowance provides coverage for preventive dental services such as cleanings and X-rays.		
Vision Services			
Routine eye exam *(up to 1 every year)*	$45 copay per visit	$40 copay per visit	$30 copay per visit
Exam to diagnose and treat diseases and conditions of the eye *(including yearly glaucoma screening)*	$0 - 45 copay per visit, depending on the service	$0 - 40 copay per visit, depending on the service	$0 - 30 copay per visit, depending on the service

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
INPATIENT AND OUTPATIENT CARE AND SERVICES			
Vision Services continued			
Annual eyewear benefit	Up to $150 allowance per calendar year	Up to $150 allowance per calendar year	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, 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. You need a referral from your PCP for diagnostic eye exams.		
Mental Health Services			
Inpatient visit	• $405 copay per day for days 1 through 4 • You pay nothing per day for days 5 through 90	• $375 copay per day for days 1 through 4 • You pay nothing per day for days 5 through 90	• $250 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90
Outpatient group or individual therapy visit	$20 copay per visit	$20 copay per 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. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. Before you receive outpatient group or individual therapy visits, you must obtain a referral from your PCP.		
Skilled Nursing Facility (SNF)			
	• $0 copay per day for days 1 through 20 • $160 copay per day for days 21 through 58 • $0 copay per day for days 59 through 100	• $0 copay per day for days 1 through 20 • $160 copay per day for days 21 through 52 • $0 copay per day for days 53 through 100	• $0 copay per day for days 1 through 20 • $160 copay per day for days 21 through 44 • $0 copay per day for days 45 through 100
What You Should Know	Our plan covers up to 100 days in a SNF.		

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
INPATIENT AND OUTPATIENT CARE AND SERVICESS			
Physical Therapy			
Occupational therapy	$40 copay per visit	$40 copay per visit	$30 copay per visit
Physical therapy and speech and language therapy	$40 copay per visit	$40 copay per visit	$30 copay per visit
What You Should Know	Before you receive occupational therapy, physical therapy, or speech and language therapy services, you must obtain a referral from your PCP.		
Ambulance			
	$325 copay per day	$250 copay per day	$200 copay per day
Transportation			
	Not covered		
Medicare Part B Drugs			
	For Part B drugs such as chemotherapy drugs: You pay 20% of the cost. Other Part B drugs: You pay 20% of the cost.	For Part B drugs such as chemotherapy drugs: You pay 20% of the cost. Other Part B drugs: You pay 20% of the cost.	For Part B drugs such as chemotherapy drugs: You pay 20% of the cost. Other Part B drugs: You pay 20% of the cost.
What You Should Know	Prior authorization may be required.		

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
PRESCRIPTION DRUG BENEFITS			
Initial Coverage			
	After you pay your yearly deductible of $200 for Tier 3, Tier 4, and Tier 5 drugs, you pay the following until your total yearly drug costs reach $3,820. 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.	After you pay your yearly deductible of $150 for Tier 3, Tier 4, and Tier 5 drugs, you pay the following until your total yearly drug costs reach $3,820. 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.	You pay the following until your total yearly drug costs reach $3,820. 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.

	CareAdvantage Preferred
PRESCRIPTION DRUG BENEFITS	
Initial Coverage	

Standard Retail Cost Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$3 copay	$6 copay	$9 copay
Tier 2 (Generic)	$12 copay	$24 copay	$36 copay
Tier 3 (Preferred Brand)	$45 copay	$90 copay	$135 copay
Tier 4 (Non-Preferred Drug)	$95 copay	$190 copay	$285 copay
Tier 5 (Specialty Tier)	29% of the cost	N/A	N/A

Standard Mail Order Cost Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$3 copay	$6 copay	$6 copay
Tier 2 (Generic)	$12 copay	$24 copay	$24 copay
Tier 3 (Preferred Brand)	$45 copay	$90 copay	$90 copay
Tier 4 (Non-Preferred Drug)	$95 copay	$190 copay	$190 copay
Tier 5 (Specialty Tier)	29% of the cost	N/A	N/A

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but 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 and Tier 2 drugs and you pay your share of the cost. After you have met your annual $200 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.

CareAdvantage Prime			CareAdvantage Premier		
One-month supply	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
$3 copay	$6 copay	$9 copay	$3 copay	$6 copay	$9 copay
$12 copay	$24 copay	$36 copay	$12 copay	$24 copay	$36 copay
$45 copay	$90 copay	$135 copay	$45 copay	$90 copay	$135 copay
$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay
30% of the cost	N/A	N/A	33% of the cost	N/A	N/A
One-month supply	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
$3 copay	$6 copay	$6 copay	$3 copay	$6 copay	$6 copay
$12 copay	$24 copay	$24 copay	$12 copay	$24 copay	$24 copay
$45 copay	$90 copay	$90 copay	$45 copay	$90 copay	$90 copay
$95 copay	$190 copay	$190 copay	$95 copay	$190 copay	$190 copay
30% of the cost	N/A	N/A	33% of the cost	N/A	N/A
If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but 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 and Tier 2 drugs and you pay your share of the cost. After you have met your annual $150 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.			If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.		

	CareAdvantage Preferred
PRESCRIPTION DRUG BENEFITS	
Coverage Gap	
	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 $3,820. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 37% of the plan's cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage	
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: • 5% of the cost, or • $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copayment for all other drugs.

CareAdvantage Prime	CareAdvantage Premier
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 $3,820. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 37% of the plan's cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.	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 $3,820. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 37% of the plan's cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: • 5% of the cost, or • $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: • 5% of the cost, or • $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copayment for all other drugs.

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
ADDITIONAL BENEFITS			
Chiropractic Care			
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	$15 copay per visit	$15 copay per visit
Initial evaluation	$15 copay	$15 copay	$15 copay
What You Should Know	Before you receive services from a specialist, 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	$40 copay per visit	$30 copay per visit
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.		
Home Health Services			
Home health agency care	You pay nothing	You pay nothing	You pay nothing
Home health infusion therapy	You pay nothing	You pay nothing	You pay nothing
What You Should Know	Prior authorization may be required.		
Hospice			
	You pay nothing	You pay nothing	You pay nothing
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.		

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
INPATIENT AND OUTPATIENT CARE AND SERVICES			
Medical Equipment/Supplies continued			
Durable medical equipment *(e.g., wheelchairs, oxygen)*	20% of the cost	20% of the cost	20% of the cost
Prosthetic devices *(braces, artificial limbs, etc.)*	20% of the cost	20% of the cost	20% of the cost
What You Should Know	Items covered by the plan: bathroom safety equipment for members who have a functional impairment when having the item will improve safety: • Standard raised toilet seat: 1 per member every five years • Standard bathroom grab bars: 2 per member every five years • Standard 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 pair every 6 months • Mastectomy sleeves for members with upper limb lymphedema: up to 2 pair every 6 months Prior authorization may be required.		
Wig allowance (for hair loss due to cancer treatment)	$500 per year	$500 per year	$500 per year
Diabetes services and supplies	You pay nothing	You pay nothing	You pay nothing
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 required for diabetes self-management training only. Coverage for blood glucose monitors, blood glucose tests strips, and glucose-control solutions is limited to the One Touch products manufactured by Lifescan, Inc. Please note that there is no preferred brand for lancets.		

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
INPATIENT AND OUTPATIENT CARE AND SERVICES			
Outpatient Substance Abuse			
Group or individual therapy visit	$20 copay per visit	$20 copay per visit	$20 copay per visit
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.		
Renal Dialysis			
	You pay nothing	You pay nothing	You pay nothing
Wellness Programs			
Weight Management Program	The plan provides a $150 annual weight management allowance towards program fees for weight loss programs such as WeightWatchers®, Jenny Craig®, or a hospital-based weight loss program.		
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.		

CarePartners of Connecticut complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CarePartners of Connecticut does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CarePartners of Connecticut:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - — Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides 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 CarePartners of Connecticut at 1-888-341-1507 (TTY: 711).

If you believe that CarePartners of Connecticut 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:

CarePartners of Connecticut, Attention:

Civil Rights Coordinator, Legal Dept.
705 Mount Auburn St.
Watertown, MA 02472
Phone: 1-888-341-1507 (TTY: 711)
Fax: 1-617-972-9048
Email: OCRCoordinator@carepartnersct.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the CarePartners of Connecticut Civil Rights Coordinator is available to help you.

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, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

carepartnersct.com | 1-888-341-1507 (TTY: 711)

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-341-1507 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-341-1507 (رقم هاتف الصم والبكم: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-341-1507 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-341-1507 (TTY: 711)。

Farsi: **توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-888-341-1507 (TTY: 711) فراهم می باشد. با تماس بگیرید.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-341-1507 (TTY : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-341-1507 (TTY: 711).

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-888-341-1507 (TTY: 711).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-341-1507 (TTY: 711).

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-341-1507 (TTY: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-341-1507 (TTY: 711) पर कॉल करें।

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-341-1507 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-888-341-1507 (TTY: 711）まで、お電話にてご連絡ください。

Khmer (Cambodian): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-341-1507 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-341-1507 (TTY: 711) 번으로 전화해 주십시오.

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-341-1507 (TTY: 711).

Navajo: Díí baa akó nínízin: Díí saad bee yáníltí'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-888-341-1507 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-341-1507 (TTY: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-341-1507 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-341-1507 (TTY: 711).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-341-1507 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-341-1507 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-341-1507 (TTY: 711).

QUESTIONS?

Call 1-888-341-1507 // TTY 711

Representatives are available Monday – Friday, 8 a.m. – 8 p.m. (From October 1 – March 31, representatives are available 7 days a week, 8 a.m. – 8 p.m.) After hours and on holidays, please leave a message and a representative will return your call on the next business day.

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This information is not a complete description of benefits. Call 1-888-341-1507 for more information.

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