

CAREPARTNERS OF CONNECTICUT HMO PLANS | 2020

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 www.carepartnersct.com.

Effective January 1, 2020–December 31, 2020
H5273_2020_5_M

SUMMARY OF BENEFITS

January 1, 2020 – December 31, 2020

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

- Representatives are available 7 days a week, 8 a.m. – 8 p.m. (Apr. 1 – Sept. 30, Mon. – Fri., 8 a.m. – 8 p.m.).

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 1-844-363-4047 (TTY: 711).
- Our website: www.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 (www.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, www.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 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. Later in this document we discuss the benefit stages: 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
<i>What You Should Know</i>	In addition, you must keep paying your Medicare Part B premium.		
Deductible			
	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)			
	\$6,700 annually	\$4,900 annually	\$3,700 annually
<i>What You Should Know</i>	<p>Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>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).</p>		

INPATIENT AND OUTPATIENT CARE AND SERVICES

Inpatient Hospital			
	<ul style="list-style-type: none"> • \$475 copay per day for days 1 through 4 • You pay nothing per day for days 5 and beyond 	<ul style="list-style-type: none"> • \$375 copay per day for days 1 through 4 • You pay nothing per day for days 5 and beyond 	<ul style="list-style-type: none"> • \$250 copay per day for days 1 through 5 • You pay nothing per day for days 6 and beyond
<i>What You Should Know</i>	Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.		
Outpatient Surgery			
Ambulatory surgical center	\$350 copay per visit	\$275 copay per visit	\$250 copay per visit
Outpatient hospital	\$350 copay per visit	\$275 copay per visit	\$250 copay per visit
<i>What You Should Know</i>	Prior authorization may be required.		

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
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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
Preventive Care			
	You pay nothing		
<i>What You Should Know</i>	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
<i>What You Should Know</i>	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 copay per PCP visit \$45 copay per Specialist visit	\$0 copay per PCP visit \$40 copay per Specialist visit	\$0 copay per PCP visit \$30 copay per Specialist visit
<i>What You Should Know</i>	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 \$60 copay per day for ultrasound	\$250 copay per day \$60 copay per day for ultrasound	\$150 copay per day \$60 copay per day for ultrasound
Diagnostic tests and procedures	\$30 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	\$10 per day per provider	\$10 per day per provider	\$10 per day per provider
<i>What You Should Know</i>	No copay for diagnostic tests and procedures, lab services, and outpatient X-rays if the services are performed as part of an office visit. Prior authorization may be required.		

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
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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 (<i>up to 1 every year</i>)	\$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 Premier level: \$1,150 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 Premier level: \$1,150 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 Premier level: \$1,150 copay per hearing aid
<i>What You Should Know</i>	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
<i>What You Should Know</i>	Limited Medicare-covered dental services do not include preventive dental services such as cleaning, routine dental exams, and dental X-rays.		
Preventive Dental benefit	You pay nothing for routine preventive and diagnostic exams and services. You pay 50% for restorative and major dental services.	\$25 copay per visit for routine preventive and diagnostic exams and services. You pay 50% for restorative services.	\$25 copay per visit for routine preventive and diagnostic exams and services. You pay 50% for restorative services.
CarePartners of Connecticut Dental Option	Covered with additional premium. See the Optional Benefits section for more information.		
<i>What You Should Know</i>	\$100 annual deductible on restorative and major dental services.		

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
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INPATIENT AND OUTPATIENT CARE AND SERVICES

Vision Services			
Routine eye exam (<i>up to 1 every year</i>)	\$15 copay per visit	\$15 copay per visit	\$15 copay per visit
Exam to diagnose and treat diseases and conditions of the eye	\$45 copay per visit	\$40 copay per visit	\$30 copay per visit
Annual glaucoma screening	\$0 copay per visit	\$0 copay per visit	\$0 copay per visit
Annual eyewear benefit	Up to \$150 allowance per calendar year	Up to \$150 allowance per calendar year	Up to \$150 allowance per calendar year
<i>What You Should Know</i>	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.		

Mental Health Services			
Inpatient visit	<ul style="list-style-type: none"> \$425 copay per day for days 1 through 4 You pay nothing per day for days 5 through 90 	<ul style="list-style-type: none"> \$375 copay per day for days 1 through 4 You pay nothing per day for days 5 through 90 	<ul style="list-style-type: none"> \$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
<i>What You Should Know</i>	<p>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.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>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.</p>		

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
Skilled Nursing Facility (SNF)			
	<ul style="list-style-type: none"> • \$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 	<ul style="list-style-type: none"> • \$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 	<ul style="list-style-type: none"> • \$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
<i>What You Should Know</i>	Our plan covers up to 100 days in a SNF.		

INPATIENT AND OUTPATIENT CARE AND SERVICES

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
Ambulance			
	\$300 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.
<i>What You Should Know</i>	Prior authorization may be required.		

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
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PRESCRIPTION DRUG BENEFITS

Initial Coverage

You pay the following until your total yearly drug costs reach \$4,020.

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.

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Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

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You pay the following until your total yearly drug costs reach \$4,020.

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 - Preferred Pharmacy

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	\$0	\$0	\$0
Tier 2 (Generic)	\$10	\$20	\$30
Tier 3 (Preferred Brand)	\$47	\$94	\$141
Tier 4 (Non-Preferred Drug)	\$100	\$200	\$300
Tier 5 (Specialty Tier)	33% of the cost	N/A	N/A
Tier 6 (Vaccines)	\$0	N/A	N/A

Standard Retail Cost Sharing - Non-preferred Pharmacy

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	\$10	\$20	\$30
Tier 2 (Generic)	\$15	\$30	\$45
Tier 3 (Preferred Brand)	\$47	\$94	\$141
Tier 4 (Non-Preferred Drug)	\$100	\$200	\$300
Tier 5 (Specialty Tier)	33% of the cost	N/A	N/A
Tier 6 (Vaccines)	\$0	N/A	N/A

Standard Mail Order Cost Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	\$0	\$0	\$0
Tier 2 (Generic)	\$10	\$20	\$20
Tier 3 (Preferred Brand)	\$47	\$94	\$94
Tier 4 (Non-Preferred Drug)	\$100	\$200	\$200
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 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 Prime	CareAdvantage Premier
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One-month supply	Two-month supply	Three-month supply
\$0	\$0	\$0
\$10	\$20	\$30
\$47	\$94	\$141
\$100	\$200	\$300
33% of the cost	N/A	N/A
\$0	N/A	N/A

One-month supply	Two-month supply	Three-month supply
\$10	\$20	\$30
\$15	\$30	\$45
\$47	\$94	\$141
\$100	\$200	\$300
33% of the cost	N/A	N/A
\$0	N/A	N/A

One-month supply	Two-month supply	Three-month supply
\$0	\$0	\$0
\$10	\$20	\$20
\$47	\$94	\$94
\$100	\$200	\$200
33% of the cost	N/A	N/A
N/A	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.

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 \$4,020. After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total \$6,350, 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 \$6,350, you pay the greater of:

- 5% of the cost, or
- \$3.60 copay for generic (including brand drugs treated as generic) and a \$8.95 copayment for all other drugs.

CareAdvantage Prime	CareAdvantage Premier
<p>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 \$4,020. After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total \$6,350, which is the end of the coverage gap.</p> <p>Not everyone will enter the coverage gap.</p>	<p>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 \$4,020. After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total \$6,350, which is the end of the coverage gap.</p> <p>Not everyone will enter the coverage gap.</p>
<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,350, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$3.60 copay for generic (including brand drugs treated as generic) and a \$8.95 copayment for all other drugs. 	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,350, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$3.60 copay for generic (including brand drugs treated as generic) and a \$8.95 copayment for all other drugs.

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
OPTIONAL BENEFITS (You must pay an extra premium each month for these benefits)			
CarePartners of Connecticut Dental Option			
	N/A	Benefits include: <ul style="list-style-type: none"> • Preventive Dental • Comprehensive Dental 	
Monthly Premium			
	N/A	Additional \$16.00 per month.	
<i>What You Should Know</i>	N/A	You must keep paying your Medicare Part B premium and your monthly plan premium.	
Deductible			
	N/A	\$100 per year	
The Plan offers the following benefits:			
	N/A	<ul style="list-style-type: none"> • Routine Preventive services covered with a \$25 copay per visit. • Fillings and extractions covered at 80%. You pay 20% after deductible. • Root canals, dentures, and crowns covered at 50%. You pay 50% after deductible. 	
<i>What You Should Know</i>	N/A	Coverage is limited to providers within the Dominion National network.	

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
ADDITIONAL BENEFITS			
BrainHQ			
	You pay nothing	You pay nothing	You pay nothing
<i>What You Should Know</i>	You can elect to enroll in a memory fitness training program offered through BrainHQ. The BrainHQ application is designed to improve attention, memory, brain speed, people skills, and intelligence.		
Chiropractic Care			
Manipulation of the spine to correct a subluxation <i>(when 1 or more of the bones of your spine move out of position)</i>	\$15 copay per visit	\$15 copay per visit	\$15 copay per visit
Initial evaluation	\$15 copay	\$15 copay	\$15 copay
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
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
<i>What You Should Know</i>	Prior authorization may be required.		
Hospice			
	You pay nothing	You pay nothing	You pay nothing
<i>What You Should Know</i>	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
ADDITIONAL BENEFITS			
Medical Equipment/Supplies			
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
<i>What You Should Know</i>	<p>Items covered by the plan: bathroom safety equipment for members who have a functional impairment when having the item will improve safety:</p> <ul style="list-style-type: none"> • 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 <p>The following additional items are covered by the plan:</p> <ul style="list-style-type: none"> • 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 <p>Prior authorization may be required.</p>		
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
<i>What You Should Know</i>	<p>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.</p> <p>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.</p>		

	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
ADDITIONAL BENEFITS			
Outpatient Substance Abuse			
Group or individual therapy visit	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit
Renal Dialysis			
	20% of the cost	20% of the cost	20% of the cost
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.		
Wellness Allowance	The plan provides a \$200 annual wellness allowance toward an activity tracker (covered once every 3 years), health club memberships, nutritional counseling, acupuncture, or fitness classes like Pilates, Tai Chi, or aerobics, and wellness programs, including memory fitness activities.	N/A	N/A
Over-the-Counter Bonus	N/A	\$40 per quarter You may use this allowance toward the purchase of Medicare-approved OTC items. Members will be able to order these items by phone or online portal.	\$40 per quarter You may use this allowance toward the purchase of Medicare-approved OTC items. Members will be able to order these items by phone or online portal.
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: 1-844-301-4010 ext. 48000 (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>.

www.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. با تماس بگیرید. 1-888-341-1507 (TTY: 711)

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 ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ថ្ងៃ ទី ១៧ ១៩៧៧ 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-341-1507 (TTY: 711).

Navajo: Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę, t'áá jiik'eh, éí ná hóló, koji' hódílnih 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 7 days a week, 8 a.m. – 8 p.m.
(Apr. 1 – Sept. 30, Mon. – Fri., 8 a.m. – 8 p.m.).

VISIT US AT: www.carepartnersct.com

CarePartners of Connecticut is an HMO plan with a Medicare contract. Enrollment in CarePartners of Connecticut depends on contract renewal.

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

Dental benefits are administered by Dominion Dental Services, Inc., which operates under the trade name Dominion National. For questions regarding your benefits or provider network, please contact Customer Service.



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