CarePartners of Connecticut

2021 Summary of Benefits

CarePartners of Connecticut HMO Plans

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

CareAdvantage Preferred (HMO)
CareAdvantage Prime (HMO)
CareAdvantage Premier (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/content/documents** to view the *Evidence of Coverage.* You can also request a printed copy by calling Customer Service at 1-888-341-1507 (TTY: 711).

Effective January 1, 2021–December 31, 2021

H5273_2021_7_M

Summary of Benefits

January 1, 2021–December 31, 2021

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 on **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 plans 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 Directory* at our website (**www.carepartnersct.com**).

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 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, CareAdvantage Prime, and 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**.

How will I determine my drug costs for CarePartners of Connecticut CareAdvantage Preferred, CareAdvantage Prime, and 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. The amount you pay also depends on whether you fill your prescription at a preferred pharmacy or a non-preferred pharmacy. Later in this document, we discuss the benefit stages: Initial Coverage, the Coverage Gap, and Catastrophic Coverage.

Monthly Plan Premium	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
	$0 per month	$30 per month	$90 per month
What You Should Know	In addition, you must keep paying your Medicare Part B premium.		
Deductible	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.

Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$7,550	$5,900	$4,700
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	CareAdvantage Prime	CareAdvantage Premier
Inpatient Hospital Care			
Inpatient hospital care	• $475 copay per day for days 1 through 4 • You pay nothing for day 5 and beyond	• $375 copay per day for days 1 through 4 • You pay nothing for day 5 and beyond	• $250 copay per day for days 1 through 5 • You pay nothing for day 6 and beyond
What You Should Know	Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.		
Outpatient Hospital Care			
Outpatient hospital services	$350 copay per day	$275 copay per day	$250 copay per day
Outpatient surgery (services provided at hospital outpatient facilities and ambulatory surgical centers)	Colonoscopies: $0 Others: $350 copay per day	Colonoscopies: $0 Others: $275 copay per day	Colonoscopies: $0 Others: $250 copay per day
What You Should Know	Before you receive out-of-network services, you must obtain a referral from your PCP. Prior authorization may be required.		
Doctor Visits			
Primary care physician	$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	You pay nothing	You pay nothing
What You Should Know	Before you receive services from out-of-network specialists, you must obtain a referral from your PCP. 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 for the same condition, you do not have to pay your share of the cost for emergency care. Your plan includes worldwide coverage for emergency care.		
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
What You Should Know	Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Copayment is not waived if admitted as an inpatient within 24 hours. Your plan includes worldwide coverage for urgently needed care.		
Diagnostic Services/Labs/Imaging			
Diagnostic radiology services (such as MRIs, CT scans)	$250 copay per day $60 per day for ultrasound	$250 copay per day $60 per day for ultrasound	$150 copay per day $60 per day for ultrasound
Diagnostic tests and procedures	$30 per day	$15 per day	$10 per day
Lab services	FIT tests: $0 Others: $5 per day	FIT tests: $0 Others: $5 per day	FIT tests: $0 Others: $5 per day
Outpatient X-rays	$10 per day	$10 per day	$10 per day
What You Should Know	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.		

Inpatient and Outpatient Care and Services	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
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 Premier level: $1,150 copay per hearing aid		
What You Should Know	Before you receive a diagnostic hearing exam from an out-of-network specialist, you must obtain a referral from your PCP. You must purchase hearing aids through Hearing Care Solutions to receive the hearing aid benefit. Up to 2 hearing aids per year, 1 hearing aid per ear. Hearing aid fitting is provided by Hearing Care Solutions at no cost.		
Dental			
Limited Medicare-covered dental services	$45 copay per visit	$40 copay per visit	$30 copay per visit
What You Should Know	Limited Medicare-covered dental services do not include preventive dental services such as cleaning, routine dental exams, and dental X-rays.		
Embedded dental benefit	• $1,500 calendar year maximum. • $0 copay for preventive services such as routine cleanings and oral exams, 50% coinsurance after deductible for restorative services such as fillings and simple extractions, and 50% coinsurance after deductible for major services such as dentures, bridges, and crowns. • $100 deductible on restorative and major services. • No waiting period.	• $750 calendar year maximum. • $25 copay for preventive services such as routine cleanings and oral exams, and 50% coinsurance after deductible for restorative services such as fillings and simple extractions. • $100 deductible on restorative services. • No waiting period.	
CarePartners of Connecticut Dental Option	N/A	Covered with additional premium. See the Optional Benefits section for more information.	
What You Should Know	Coverage is limited to providers within the Dominion PPO network.		
Vision Services			
Routine eye exam (up to 1 every year)	$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

Inpatient and Outpatient Care and Services	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
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
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. A referral is required from your PCP before you receive a diagnostic eye exam from an out-of-network provider.		
Mental Health Services			
Inpatient visit	• $425 copay per day for days 1 through 4 • You pay nothing for days 5 through 90	• $375 copay per day for days 1 through 4 • You pay nothing for days 5 through 90	• $250 copay per day for days 1 through 5 • You pay nothing for days 6 through 90
Outpatient group or individual therapy visit	$30 copay per visit	$30 copay per visit	$30 copay per visit
What You Should Know	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital. Before you receive outpatient group or individual therapy visits from an out-of-network provider, you must obtain a referral from your PCP.		
Skilled Nursing Facility (SNF)			
Skilled nursing facility (SNF)	• $0 copay per day for days 1 through 20 • $178 copay per day for days 21 through 59 • $0 copay per day for days 60 through 100	• $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 per benefit period. No prior hospital stay is required.		
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 from an out-of-network provider, you must obtain a referral from your PCP.		
Ambulance			
Ambulance	$300 copay per day	$250 copay per day	$200 copay per day
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 20% of the cost. Other Part B drugs: You pay 20% of the cost.		
What You Should Know	Prior authorization may be required.		

Prescription Drug Benefits: Initial Coverage	CareAdvantage Preferred CareAdvantage Prime CareAdvantage Premier		
	• There is no deductible for the CareAdvantage Preferred, CareAdvantage Prime, and CareAdvantage Premier plans. • You pay the following until your total yearly drug costs reach $4,130. 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	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Generic)	$0	$0	$0
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
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
Mail Order Cost Sharing			
Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Generic)	$0	$0	$0
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. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.		

Prescription Drug Benefits: Coverage Gap	CareAdvantage Preferred 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 $4,130. 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 $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Prescription Drug Benefits: Catastrophic Coverage	CareAdvantage Preferred CareAdvantage Prime CareAdvantage Premier
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay the greater of: • 5% of the cost, or • $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copayment for all other drugs.

OPTIONAL BENEFITS (You must pay an extra premium each month for these benefits)	**CareAdvantage Preferred**	**CareAdvantage Prime**	**CareAdvantage Premier**
CarePartners of Connecticut Dental Option			
Benefits include	N/A	• Preventive dental • Comprehensive dental	
Monthly premium	N/A	Additional $15.00 per month.	
What You Should Know	N/A	You must keep paying your Medicare Part B premium and your monthly plan premium.	
Deductible	N/A	$100 per year on restorative and major services.	
The CarePartners of Connecticut Dental Option offers the following benefits:	N/A	• $1,000 calendar year maximum • $25 copay for preventive services such as routine cleanings and oral exams (only one $25 copay will apply towards a single office visit) • 20% coinsurance after deductible for restorative services such as fillings and simple extractions • 50% coinsurance after deductible for major services such as dentures, bridges, and crowns • No waiting period	
What You Should Know	N/A	• The CarePartners of Connecticut Dental Option is not additional to the embedded dental benefits described above under "Embedded dental benefit." If you purchase the CarePartners of Connecticut Dental Option, it replaces the embedded dental benefit. • Coverage is limited to providers within the Dominion PPO network	

Additional Benefits	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
Acupuncture			
Acupuncture services	$10 copay per visit	$10 copay per visit	$10 copay per visit
What You Should Know	Medicare covers up to 12 visits in 90 days for members with chronic low back pain. 8 additional visits covered for those demonstrating an improvement. No more than 20 visits administered annually. Before you receive services from an out-of-network provider, you must obtain a referral from your PCP. Additional acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. See additional details under "Wellness Programs."	Medicare covers up to 12 visits in 90 days for members with chronic low back pain. 8 additional visits covered for those demonstrating an improvement. No more than 20 visits administered annually. Before you receive services from an out-of-network provider, you must obtain a referral from your PCP.	
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	$15 copay per visit	$15 copay per visit
Initial evaluation (once per year)	$15 copay per visit	$15 copay per visit	$15 copay per visit
What You Should Know	Before you receive services from an out-of-network provider, you must obtain a referral from your PCP.		
Foot Care (podiatry services)			
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	$45 copay per visit	$40 copay per visit	$30 copay per visit
What You Should Know	Before you receive services from an out-of-network provider, you must obtain a referral from your PCP.		
Home Health Services			
Home health agency care	You pay nothing	You pay nothing	You pay nothing
Home infusion therapy	You pay nothing	You pay nothing	You pay nothing
What You Should Know	Prior authorization may be required for home infusion therapy services.		

Additional Benefits	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
Hospice			
	Benefit provided by Medicare	Benefit provided by Medicare	Benefit provided by Medicare
What You Should Know	You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.		
Medical Equipment/Supplies			
Durable medical equipment (e.g., wheelchairs, oxygen)	20% of the cost	20% of the cost	20% of the cost
Prosthetic devices (e.g., braces, artificial limbs, etc.)	20% of the cost	20% of the cost	20% of the cost
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: • 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 pairs every 6 months • Mastectomy sleeves for members with upper limb lymphedema: up to 2 pairs every 6 months Prior authorization may be required.		
Wig allowance (for hair loss due to cancer treatment)	$500 per year	$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 is required for out-of-network diabetes self-management training. 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.		
Outpatient Substance Abuse			
Group or individual therapy visit	$30 copay per visit	$30 copay per visit	$30 copay per visit
Renal Dialysis			
	20% of the cost	20% of the cost	20% of the cost
Telehealth/Telemedicine Services			
	Medicare-covered services plus additional telehealth services including PCP services, specialist services, and more. Applicable office visit cost share applies for non-opioid telehealth services; Opioid services cost share applies to opioid telehealth aervices rendered as part of an Opioid Treatment Program Services episode. Referral is required to receive certain out-of-network telehealth services.		

Additional Benefits	CareAdvantage Preferred	CareAdvantage Prime	CareAdvantage Premier
Wellness Programs			
Over-the-counter (OTC) for Medicare items	$25 per calendar quarter	$40 per calendar quarter	$40 per calendar quarter
What You Should Know	No rollover of unused calendar quarter balance. Items available only from the OTC catalog supplied by the plan-approved vendor.		
Weight Management program	The plan provides a $150 annual Weight Management reimbursement 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 $175 annual Wellness reimbursement toward health club memberships, nutritional counseling, acupuncture, or fitness classes like Pilates, tai chi, or aerobics, and wellness programs, including memory fitness activities.	N/A	N/A
What You Should Know	Does not include meals or other program items, such as scales.	N/A	N/A
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

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 (TDD: 1-800-537-7697)

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

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, ໂດຍບໍ່ເສັ້ງຄ່າ, 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

Visit us at **www.carepartnersct.com,** or call **1-844-399-7483 (TTY: 711)**.

CarePartners of Connecticut

705 Mount Auburn Street
Watertown, MA 02472