



2021 Summary of Benefits

CarePartners Access (PPO) offered by CarePartners of Connecticut

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

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).

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 Access (PPO)).

Tips for comparing your Medicare choices

This *Summary of Benefits* booklet gives you a summary of what CarePartners Access (PPO) 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 Access (PPO)

Who can join?

To join CarePartners Access (PPO), 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 Access (PPO) has a network of doctors, hospitals, pharmacies, and other providers. 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**).

Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in emergency or urgent situations, non-contracted providers may deny care. In addition, if you use an out-of-network provider, your share of the cost for covered services may be higher.

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 Access (PPO) covers Part D drugs. In addition, CarePartners Access 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 Access (PPO)?

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.

	CarePartners Access
Monthly Plan Premium	
	\$0 per month
What You Should Know	In addition, you must keep paying your Medicare Part B premium.
Deductible	\$1,000 for in- and out-of-network services combined.
What You Should Know	The deductible only applies to certain services as noted.

Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	\$7,550 for in and out-of-network services combined.
What You Should Know	<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	CarePartners Access In-network	CarePartners Access Out-of-network
Inpatient Hospital Care		
Inpatient hospital care	\$795 copay per stay after deductible	30% of the cost after deductible
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	\$250 copay per day after deductible	30% of the cost after deductible
Outpatient surgery (services provided at hospital outpatient facilities and ambulatory surgical centers)	Colonoscopies: \$0 Others: \$250 copay per day after deductible	30% of the cost after deductible
What You Should Know	Prior authorization may be required for in-network services.	
Doctor Visits		
Primary care physician	\$0 copay per visit	\$20 per visit after deductible
Specialist	\$45 copay per visit	\$50 per visit after deductible
Preventive care	\$0 copay per visit	30% of the cost
What You Should Know	Any additional preventive services approved by Medicare during the contract year will be covered. Out-of-network preventive barium enemas, diabetes self-management training, and digital rectal prostate cancer screening exams are subject to the deductible.	
Emergency care	\$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.	

Inpatient and Outpatient Care and Services	CarePartners Access In-network	CarePartners Access Out-of-network
Urgently needed services	\$45 copay per visit	\$45 copay per visit
What You Should Know	Copayment is not waived if admitted as an inpatient within 24 hours. Your plan includes worldwide coverage for urgently needed care.	
Diagnostic Services/Labs/Imaging		
Diagnostic radiology services (such as MRIs, CT scans)	\$60 per day for ultrasound. \$250 per day for all other Medicare-covered diagnostic radiology services.	30% of the cost after deductible
Diagnostic tests and procedures	\$40 per day	30% of the cost after deductible
Lab services	\$0 per day	30% of the cost after deductible
Outpatient X-rays	\$10 per day	30% of the cost after deductible
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 for in-network services.	
Hearing Services		
Exam to diagnose and treat hearing and balance issues	\$45 copay per visit	\$50 copay per visit after deductible
Routine hearing exam (up to 1 every year)	\$0 copay per visit	\$50 copay per visit after deductible
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	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. Cost-share for hearing aid fitting is \$0 if provided by Hearing Care Solutions, and 30% coinsurance for other providers.	
Dental		
Limited Medicare-covered dental services	\$40 copay per visit	\$50 copay per visit after deductible
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	\$1,000 calendar year maximum. \$0 for preventive services such as cleanings and oral exams, 50% coinsurance for restorative services such as fillings and simple extractions, and 50% coinsurance for major services such as dentures, bridges, and crowns. No waiting period.	
What You Should Know	The plan is administered by Dominion Dental Services, Inc., which operates under the trade name Dominion National. A member may choose to receive treatment from any licensed dentist. Services rendered by providers outside of the Dominion PPO Network are based on procedure classification, and 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.	

Inpatient and Outpatient Care and Services	CarePartners Access In-network	CarePartners Access Out-of-network
Vision Services		
Routine eye exam (up to 1 every year)	\$0 copay per visit	30% of the cost after deductible
Exam to diagnose and treat diseases and conditions of the eye	\$45 copay per visit	\$50 copay per visit after deductible
Annual glaucoma screening	\$0 copay per visit	30% of the cost after deductible
Annual eyewear benefit	Up to \$150 allowance per calendar year	
What You Should Know	If you purchase your glasses, frames, prescription lenses, or contacts from a participating vision provider in the EyeMed Vision Care network, the \$150 allowance is applied at the point of sale. Otherwise, you must pay out-of-pocket and submit for reimbursement.	
Mental Health Services		
Inpatient visit	\$1,763 per stay after deductible	30% per stay after deductible
Outpatient group or individual therapy visit	\$40 copay per visit	30% of the cost after deductible
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.	
Skilled Nursing Facility (SNF)		
Skilled nursing facility (SNF)	<ul style="list-style-type: none">\$0 copay after deductible for days 1 through 20\$178 copay per day after deductible for days 21 through 100	30% of the cost after deductible
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	30% of the cost after deductible
Physical therapy and speech and language therapy	\$40 copay per visit	30% of the cost after deductible
Ambulance		
Ambulance	\$325 copay per one-way trip	\$325 copay after deductible 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	<p>For Part B chemotherapy drugs: You pay 20% of the cost.</p> <p>Other Part B drugs: You pay 20% of the cost.</p>	30% of the cost after deductible
What You Should Know	Prior authorization may be required for in-network services.	

**Prescription Drug Benefits:
Initial Coverage**
CarePartners Access

- There is no deductible for CarePartners Access.
- 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	CarePartners Access
	<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 \$4,130.</p> <p>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.</p> <p>Not everyone will enter the coverage gap.</p>

Prescription Drug Benefits: Catastrophic Coverage	CarePartners Access
	<p>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:</p> <ul style="list-style-type: none"> • 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.

Additional Benefits	CarePartners Access In-network	CarePartners Access Out-of-network
Acupuncture		
Acupuncture services	\$10 copay per visit	\$50 copay per visit after deductible
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.	
Chiropractic Care		
Manual manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)	\$20 copay per visit	\$50 copay per visit after deductible
Initial evaluation (once per year)	\$20 copay per visit	\$50 copay per visit after deductible
Foot Care (podiatry services)		
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	\$45 copay per visit	\$50 copay per visit after deductible
Home Health Services		
Home health agency care	You pay nothing	30% of the cost after deductible
Home infusion therapy	You pay nothing	30% of the cost after deductible
What You Should Know	Prior authorization may be required for in-network home infusion therapy services..	
Hospice		
	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	30% of the cost after deductible
Durable medical supplies (e.g., catheters, gauze)	\$40	30% of the cost after deductible
Prosthetic devices (e.g., braces, artificial limbs, etc.)	20% of the cost	30% of the cost after deductible
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: <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 The following additional items are covered by the plan: <ul style="list-style-type: none">• 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 for in-network services.	

Additional Benefits	CarePartners Access In-network	CarePartners Access Out-of-network
Wig allowance (for hair loss due to cancer treatment)	\$500 per year	
Diabetes services and supplies	You pay \$0 for OneTouch products manufactured by LifeScan, Inc. You pay 20% for non-OneTouch products.	You pay \$0 after deductible for OneTouch products manufactured by LifeScan, Inc. You pay 30% of the cost after deductible for non-OneTouch products.
What You Should Know	Includes diabetes monitoring supplies, diabetes self-management training, and therapeutic shoes or inserts. Additional cost shares may apply if you receive other medical services during the same office visit. Coverage for blood glucose monitors, blood glucose tests strips, and glucose-control solutions is limited to the OneTouch products manufactured by Lifescan, Inc. Please note that there is no preferred brand for lancets. Non-OneTouch products require a coverage exception request from the member or their provider to be covered.	
Outpatient Substance Abuse		
Group or individual therapy visit	\$40 copay per visit	30% of the cost after deductible
Renal Dialysis		
	20% of the cost after deductible	30% of the cost after deductible
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 services rendered as part of an Opioid Treatment Program Services episode.	Medicare-covered services only. Additional telehealth services are not covered out-of-network. Applicable office visit cost share applies for non-opioid telehealth services; Opioid services cost share applies to opioid telehealth services rendered as part of an Opioid Treatment Program Services episode.
Wellness Programs		
Over-the-counter (OTC) for Medicare items	\$50 per calendar quarter	Items available only through plan-approved OTC vendor.
What You Should Know	No rollover of unused calendar quarter balance. Items available only from the OTC catalog supplied by the plan-approved vendor.	
SilverSneakers®	You pay nothing for membership.	\$0 for at-home exercise kits.
What You Should Know	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. Out-of-network facilities are not available.	

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.

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) فراموش نکنید.

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 નિઃશુલ્ક ભાષા સહાયતા 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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតល្បួលគឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ 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: ໂປດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-341-1507 (TTY: 711).

Navajo: Díí baa akó nínízin: Díí saad bee yánílt'igo Diné Bizaad, saad bee áká'ánída'áwođęę, t'áá jiikeh, 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 1-844-399-7487 (TTY: 711).



705 Mount Auburn Street
Watertown, MA 02472

CarePartners of Connecticut is a PPO 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 (TTY: 711) 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. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2020 Tivity Health, Inc. All rights reserved. Out-of-network/non-contracted providers are under no obligation to treat CarePartners of Connecticut PPO members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.