Aetna® health maintenance organization (HMO) plans — Colorado

Network access plan

This manual will help you understand our health programs and policies. And we'll be right there with you, throughout all of life's stages.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company, Aetna Health Inc. and their affiliates (Aetna). Aetna is part of the CVS Health® family of companies. Each insurer has sole financial responsibility for its own products.

Table of contents

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1. Introduction

This Colorado network access plan is for Aetna® health maintenance organization (HMO) plans (Net ID 2089). The Colorado Division of Insurance has licensed Aetna Health Inc. (Aetna) as an HMO.

The Aetna HMO Colorado network offers health plans in 15 counties. The counties are: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Elbert, Fremont, Jefferson, Larimer, Mesa, Pueblo, Teller and Weld.

We are required as an issuer to create an access plan specific to each network. This access plan describes our strategy, policies, and procedures to create, maintain and administer an adequate network.

The Aetna HMO Colorado network access plan is applicable to the following fully insured products:

- Aetna® HMO
- Aetna Health Network Only℠
- Aetna Health Network Option℠
- Aetna HealthFund®
- Quality Point-of-Service® (QPOS®)

Our main goal

We work every day to ensure the power of health is in your hands. We strive to see the world from your eyes. You can make confident choices and live a healthier life with our support and tools. And with us, you'll find convenient tools and resources that fit your life.

You pay less out of pocket when you use doctors and hospitals in our network. Our networks focus on quality and efficiency. This improves the health care experience for all. And members find it easy to get the care they need.

The network includes doctors, hospitals and other health care professionals and facilities in the Colorado market. We negotiate discounted rates for covered health care services. In-network doctors and hospitals won't bill you for costs above our rates for covered services.

Our access plan provides a broad view of plan policies and procedures that cover participating providers and facilities. This material is for information only. It is neither an offer of coverage nor medical advice. It's only a partial, general description of plan or program benefits. It isn't a contract. Consult your plan documents (such as the Schedule of Benefits or the Certificate of Coverage) to find governing contractual provisions, including procedures, exclusions and limitations relating to the health plan. If there's a conflict between the plan documents and this access plan, the plan documents will govern.

We don't provide health care services, so we can't guarantee any results or outcomes. We don't advise the self-management of health problems, nor do we promote any particular form of medical treatment. Consult your health care provider for the care that's right for your specific medical needs.

We've created certain policies and procedures to ensure our members get access through the Colorado network for Aetna® Open Access Managed Care, EPO, and PPO plans. You'll find a brief description in these sections of this access plan. Unless stated otherwise, this access plan also includes facilities.

Visit **Aetna.com** to get more information about the network.

If you're a member, to reach Aetna, use the toll-free phone number on your Aetna® member ID card. Not yet a member? Call **1-888-98-Aetna (TTY: 711)** or **1-888-982-3862 (TTY: 711)**.

This network access plan is available upon request. Call the toll-free phone number on your Aetna member ID card. Or write to: Aetna, 4582 South Ulster Street Parkway, Suite 900, Denver, CO 80237.

This access plan also includes information for both the Aetna national pharmacy and other Aetna managed pharmacy networks.

2. Network adequacy

Our network numbers

As of August 2024, the Aetna® HMO Colorado network includes:

- 9,156 primary care providers
- 28,645 medical specialists
- 2,444 obstetricians and/or gynecologists
- 2,858 pediatricians
- 184 urgent care facilities
- 858 pharmacies
- 137 hospitals; 160 ERs
- 124 behavioral health, mental health, and 110 substance abuse disorder facilities
- 29,552 behavioral health and 1,641 substance abuse disorder providers

Provider and facility availability

We've created provider standards for access to care and service that comply with Colorado regulations. This is to ensure that our network has enough licensed health care providers available to meet members' needs. The Aetna National Quality Oversight Committee (NQOC) assesses these standards, which include:

- Adequate provider-to-enrollee ratio (examples of providers are PCPs, obstetricians and gynecologists, behavioral health care providers, and specialists)
- Geographic distribution (participating providers are within a reasonable proximity to members)
- Appointment availability (service and wait times)
- An assessment of cultural needs, linguistic needs, and cultural and linguistic preferences of members

At least once every year, we check network adequacy based on member needs. We use the results to develop and implement market contracting plans.

For telehealth services, we provide the same benefit for covered services, whether the providers see you in their office or consult with you via telehealth. This helps to meet your health care needs, and gives you access to health care services.

In remote or rural areas, occasionally availability standards are not able to be met due to lack of, or absence of, qualified providers and/or hospital facilities. Even in counties where there may not be a pediatrician or Ob/Gyn available, there are participating PCPs who can provide services to our members. We monitor counties for new providers and facilities and reach out to pursue signing a contract with them.

We meet the availability (the provider to enrollee ratio) standards for each county of the network for primary care, pediatrics, obstetricians and gynecologists, behavioral health providers, and substance use disorder care providers.

Measurable process for access to care and service

The state insurance regulation and the Aetna National Quality Oversight Committee (NQOC) create standards for service and wait time. We monitor these standards to help ensure our members receive care within a reasonable time period.

Each year, we measure service standards in these ways:

- We monitor access to primary care physicians (PCPs) for routine care appointments, preventive well visits, urgent care appointments, and after-hours care. To do this, we conduct annual surveys with our Colorado providers.
- We monitor access to specialty care, and prenatal care, and to high-volume and high-impact providers for routine care, and urgent care, and after-hours care. To do this, we conduct annual surveys with our Colorado providers.
- We check Member Services telephone access by reviewing call abandonment rates, average speed of answer, and total service factors. We also track member complaint data.

Each year, we measure behavioral health accessibility standards in these ways:

- We monitor access for routine behavioral health care, urgent care appointments, and after-hours care. We look at member complaints, behavioral health member experience and provider experience survey data, and/or phone surveys.
- We monitor access to behavioral health Member Services by reviewing call abandonment rates and calls answered within 30 seconds. We also track member complaint data.

If we see opportunities for quality improvement, we prioritize and implement them.

Provider selection and criteria — how we build our networks

To build a robust provider network, we carefully review the providers available in each region, county and municipality. We make sure there is a broad range of qualified providers so that access to care is safe and convenient.

Aetna pursues all available qualified providers. Providers must meet our high standards before we ask them to join our network.

Our network includes primary care providers, specialists, hospitals and other facilities. We want to ensure that members have access to the right medical services.

How we choose providers

• Physicians

To be in our network, providers must:

- Pass our credentialing process
- Work with our medical benefits programs, including preventive care
- File claims on behalf of our members
- Accept our fees
- Agree to not bill the member for covered services charges that are over our fee
- Have active admitting privileges in at least one network hospital (depending on provider specialty)

• Hospitals

To be in our network, hospitals must have a current license and be accredited by one of these entities:

- The Joint Commission (TJC)
- The American Osteopathic Association (AOA)
- Det Norske Veritas Healthcare, Inc. (DNVHC)
- An accrediting entity that meets Aetna® policy and/or business participation requirements or state/regulatory standards

These entities perform detailed reviews of hospitals, including on-site visits. Hospitals also need to show them their quality improvement activities.

If a hospital is not accredited from these entities, then they need to meet these alternative requirements:

- They must complete an on-site quality assessment.
- If the Centers for Medicare & Medicaid Services (CMS) or a state survey has a similar review process as Aetna, we may substitute the CMS or state survey for an on-site quality assessment.

Our contracts require hospitals to participate in our quality and patient management activities. Facilities must notify us of any material change of licensure or accreditation status. They must have adequate liability insurance or self-insurance. They must provide proof of insurance upon request.

Every three years, our credentialing team reviews the following for each hospital in our network. They make sure that the hospitals:

- Are in good standing with state and federal regulatory bodies
- Are accredited by an Aetna-recognized accrediting entity
- Have liability insurance limits
- Have a Medicare certification number, when applicable

• More services

We also have participation standards for every type of provider service in our network, including:

- Free-standing surgical centers
- Urgent care centers
- Skilled nursing facilities
- Hospices
- Ambulance services
- Home health care agencies
- Laboratories
- X-ray facilities

Participation criteria may vary based on specialty, market, and applicable local, state, or federal laws.

Facilities must meet required:

- Licensing
- Certification
- Professional staffing standards
- Access standards
- Patient emergency standards

They must also:

- Have certain levels of liability insurance
- Follow patient confidentiality rules

All network providers must have:

- Proper licensing
- Appropriate education
- Appropriate training
- Applicable board certifications
- Certain levels of liability insurance

They must also not have:

- A history of professional liability claims
- A work history that would raise concerns for our members

How we build our pharmacy networks

We look at the number of pharmacies in a specific area. This way, we can make sure we have enough providers to meet your pharmacy needs. So you don't have to spend a lot of time looking for a pharmacy.

How we choose our pharmacy providers

We created the pharmacy networks based on many market variables. We chose providers based on:

- Access and availability
- Our credentialing standards
- The ability to meet our participation criteria

Pharmacy quality assurance procedures

Ongoing monitoring of network pharmacy providers includes all of the actions listed below:

- Requiring network pharmacy providers to participate in recredentialing every two years
- Checking federal exclusion lists from the Office of Personnel Management and the Office of the Inspector General to see if network pharmacy providers have been added to either
- Tracking potential quality-of-care issues from member complaints and internally identified events

Quality measures

Our quality measures are based on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®).*
Our quality measures include:

- Blood sugar control for diabetics
- Antidepressant medication management
- Breast cancer screening
- Cervical cancer screening
- Colon cancer screening
- Statin therapy for diabetics
- Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication
- Initiation and engagement of alcohol and other drug dependence treatment
- Controlling high blood pressure
- Other preventive care measures

Each year, we check to see how close we are to meeting our goals. Here's what we did:

We collected data on a set of clinical measures called Healthcare Effectiveness Data and Information Set (HEDIS®), as applicable. We shared the results with the National Committee for Quality Assurance (NCQA) Quality Compass®. The NCQA makes the results public. Each year, we use the results to set new goals and improve selected measures. And we improved performance on many measures.

For more information on our Quality Program - **https://www.aetna.com/individuals-families/member-rights-resources/commitment-quality/quality-management.html**.

All doctors and hospitals must meet certain standards and agree to accept our rates before joining our network.

Visit **Aetna.com/docfind/cms/html/MedicalCredentialing.html** to learn how we credential primary care physicians and specialists.

Quality management program and scope

Our quality management program checks and improves the quality and safety of clinical care and services to members. The quality management program includes but is not limited to:

- Assisting in the development of provider performance programs
- Development of written policies and procedures reflecting current standards of clinical practice
- Development, implementation and monitoring of patient safety initiatives, and preventive and clinical practice guidelines
- Establishing standards for and auditing of medical and behavioral health record documentation
- Evaluation of accessibility and availability of network providers
- Evaluation of member experience and practitioner satisfaction
- Monitoring of medical and behavioral health population health management programs
- Oversight of delegated activities
- Performing credentialing and recredentialing activities
- Review and evaluation of preventive and behavioral health services; ambulatory, inpatient, primary, and specialty care; high-volume and high-risk services; and continuity and coordination of care
- Supporting initiatives to address healthcare disparities associated with race, ethnicity, sexual orientation, gender identity and social determinants of health

Member experience

We work hard to support providers and members and create a culture of better health — one that is connected, simpler, intuitive, convenient, affordable and powerful.

Providers influence the consumer experience. We help providers with tools, information and payment models.

Members deserve quality experiences, so we ask questions and work to improve their experiences. To do this, we send out surveys via a certified vendor, hold member experience work groups, and analyze member complaints and appeals.

For example, a vendor sends a survey annually to a number of members who are 18 and older and have used behavioral health care. We use the responses to measure members' experience of behavioral health services and administrative services.

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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The vendor also sends out a survey once a year to members who participated in case management or disease management programs. We find out how well our programs met our members' expectations.

In addition, we encourage members to offer suggestions and express their concerns through our customer service phone lines and our member website.

Our outreach helps us better understand both where our programs perform well and areas in which we need to improve.

Monitoring access

We continue to monitor and improve availability and access to providers and facilities. Here are steps we routinely take:

- Every year, we measure and analyze:
  - Geographic distribution of providers
  - Member-to-practitioner ratios
  - Member complaints
  - Closed practice data — specifically against the goals and standards for availability
  - Tracking and trending of data relating to the network
- We review counties where enrollees don't have easy access to care. We try to determine availability of providers and, when possible, recruit them.

Accessing services outside the network

You can get a service or supply from an out-of-network provider at the same out-of-pocket cost share as a network provider, if you can't:

- Get a medically necessary service or supply through an in-network physician or hospital without unreasonable delay
- Find a participating physician who can provide the service or supply within the appointment wait time and distance standards required by Colorado Regulation 4-2-53, Section 6.

You must get the service or supply pre-certified first. Then we'll cover it at the in-network benefits level. That means you'll pay your share of the costs (copayment, coinsurance, and/or deductible) at the in-network level. Medical emergencies don't require pre-certification. Your share of the costs for medical emergencies will also be at the in-network level.

- Every year, we track nonparticipating provider approval requests and report the data to the NQOC.
- Network staff monitor access to hospital-based providers at participating facilities and attempt to put new contracts in place where we have deficiencies.
  - Members who receive services from a nonparticipating provider at a participating facility will have no greater cost share than if the service or treatment was done by a participating provider.
- Members who receive services from a nonparticipating provider at a participating facility will have no greater cost share than if the service or treatment was done by a participating provider.

Provider directories

To find a provider, use the printed provider directory or the online search tool.

- Printed provider directory
  - We publish a fully updated directory monthly.
  - To get a directory and get on the list to receive the addenda, call the toll-free phone number on your Aetna® member ID card or send us a written request.
- Online provider search tool
  - Go to **Aetna.com** and visit your member website to use the tool.
  - It's usually updated six days a week.

3. Network access plan procedures for referrals

Referrals within the provider network

Some health plans require you to get a referral from your PCP to get care from a specialist. Please refer to your plan documents to see:

- If you need to select a PCP
- Whether a PCP must refer you to a specialist before you can get access to a specialist's services

If you need a referral, contact your PCP before you get specialty care. You can find in-network specialists listed in our online provider search tool. This tool offers the most up-to-date list of doctors, hospitals and health care professionals in our network. To use it, go to **Aetna.com** and sign in to your member website. If you don't have access to the internet, call the toll-free phone number on your Aetna member ID card to get a printed directory.

- Referral options may be restricted to fewer than all providers in the network who are qualified to provide covered specialty services.

  While a member can be referred to any provider in the network, certain doctors may be affiliated with integrated delivery systems, independent practice associations or other provider groups. Members who select these doctors will generally be referred to specialists and hospitals within that system or group.

- Members may get timely referrals for access to specialty care.

  Some plans may require PCP selection and PCP referrals for specialty care. In such cases, a member may get specialty care by consulting their PCP. Referrals not requiring prior authorization are valid as soon as the PCP requests it. Network doctors and other health care providers are required by contract to follow access standards for care. Any plan that has a PCP referral requirement gives members direct access to benefits for medical emergency services, urgent care or Ob/Gyn visits. Plans that don't require referrals permit members to go to any participating specialty care provider to receive network benefits.
- Members may expedite the referral process when indicated by their medical condition.

  For referrals requiring prior authorization by us, we'll notify you within 5 business days for non-urgent requests. For urgent requests, we'll inform you no later than 2 business days (and not to exceed a total of 72 hours from when we receive the original request). You may expedite the prior authorization process when medically appropriate by consulting your PCP.
- Referrals cannot be retroactively denied or changed except for fraud or abuse.

  We can't retrospectively deny or change referrals approved by us, except for fraud or abuse.

4. Network access plan disclosures and notices

Grievance and appeal

You can find grievance procedures in a number of documents. These include member disclosures and plan documents, including the Certificate of Coverage and the Summary of Benefits and Coverage (SBC). The grievance procedures are also on our website. The Explanation of Benefits (EOB) statement also provides information that addresses members' rights.

If you disagree with something we've done, you can talk to us on the phone. Or you can mail us a written complaint. The phone number is on your Aetna member ID card. You can also email us through the Message Center when you log in to **Aetna.com**.

Still not satisfied?

You can file an appeal

Did we deny your claim? Directions on how to appeal our decision are in:

- The letter we sent you
- The Explanation of Benefits statement that says your claim was denied

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination. You can appeal by sending a written appeal to the address on the notice of adverse benefit determination. Or you can call the number on your ID card.

You need to include:

- The member's name
- Your employer's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by calling the number on your ID card.

The form will tell you where to send it to us. We will assign your appeal to someone who was not involved in making the original decision.

You can appeal two times under this plan. The second level of internal review is at your option. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

- For an urgent care claim (such as if your doctor decides a delay in getting medical care could put your health at risk), we will make a decision in 36 hours.
- For a pre-service claim, which requires us to precertify the services, we will make a decision within 15 days.
- For a post-service claim, we will make a decision within 30 days.

You may be able to get a review from someone outside Aetna if:

- we based our decision on a medical judgement, or
- you want an independent review to determine if out-of-network services are eligible at the in-network level of coverage.

Just follow the instructions on our response to your appeal. For more information, visit **Aetna.com** and put "external review" in the search bar.

In most cases, you will need to exhaust all of your internal appeals first. External Reviews must be submitted to Aetna within 4 months of the day you received the decision from us.

Specialty medical services

You can find information on available specialty medical services in the plan documents. These include the Certificate and the SBC. The Certificate describes the benefits and the SBC shows available services, cost-sharing amounts and visit limits. The SBC also shows some common medical events and the therapy services that may help to treat them.

Emergency and nonemergency medical care

You'll find information on our procedures for providing emergency and nonemergency medical care in the plan and member disclosure documents. Or go to **Aetna.com** the information.

These documents and our website also define:

- What an emergency medical condition is
- What to do when an emergency occurs
- Where to go for treatment
- Differences between nonurgent care and an emergency
- Processes a member must follow

Access and accessibility of services of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds and with physical or mental disabilities

Aetna® uses Language Line Services, an interpretation service, to address the needs of enrollees with limited English proficiency. Language Line Services offers 24/7 over-the-phone interpretation in over 200 languages. Explanation of Benefits (EOB) statements and other correspondence generated through the claims and appeal process provide notice that translation services are available. And Aetna member disclosure information (available to members on our public website as well as in enrollment packets) includes a notice that language services are available for members who speak another language or are hearing impaired.

For hearing-impaired or speech-disabled individuals, Aetna uses a relay service. The relay service acts as an intermediary for telecommunications between hearing individuals and individuals who are deaf, hard of hearing, deaf-blind and/or have speech disabilities. We have specially trained communication assistants who complete the calls and stay online to relay messages either:

- Electronically over a teletypewriter (TTY) or telecommunications device for the deaf (TDD), or
- Verbally to hearing parties

Aetna doesn't consider the member's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when providing access to care.

Aetna and participating providers must comply with these laws:

- Title VI of the Civil Rights Act of 1964
- The Age Discrimination Act of 1975
- The Americans with Disabilities Act
- Laws that apply to those who receive federal funds
- All other laws that protect your rights to receive health care

If a member chooses to provide certain information about race, ethnicity and languages spoken, it may help to improve access to health care and better serve a member. All information that a member provides is private. The member disclosure document addresses privacy and access to health care in more detail.

Assessing health care needs

We're working hard to improve the service, quality and safety of health care. Through our quality management program and strategy, we assess, measure and monitor the care provided. The member disclosure form has online search instructions on how to find information about quality management programs. A printed copy of this information is also available. Call Member Services at the number on your Aetna member ID card.

Program information includes goals, scope and outcome with clinical data and is publicly available on our website. Go to **Aetna.com/individuals-families/member-rights-resources/commitment-quality/quality-management.html** to read the information.

5. Plans for coordination and continuity of care

Keeping the provider you go to now

You may have to find a new provider when you:

- Join our plan and the provider you have now is not in the network
- Are already a member and your provider stops being in our network

But in some cases, you may need to complete a treatment or have treatment that was already scheduled. And you may continue to go to your current provider. This is called continuity of care or transition of care. Transition of care services require prior approval.

If you join a plan and you're in an active course of treatment with a provider or facility who is not in the network, we'll provide transition-of-care benefits. Transition of care gives you temporary coverage as we transfer services from an out-of-network specialty provider to an in-network specialty provider.

For transition-of-care coverage requests due to a provider or facility becoming inactive, we provide continuity of care coverage:

- For an active course of treatment with a provider that includes having undergone treatment, or having been seen at least once in the last 12 months, as long as you have not been released from treatment.
- For transition of care coverage requests for maternity care, an active course of treatment begins after the first completed visit with an obstetrician and a treatment plan is started through the postpartum period.
- For transition-of-care coverage requests for primary care, we'll allow an active course of treatment for pediatrics, general practice, family medicine, internal medicine, obstetrics-gynecology, physician assistants and nurse practitioners supervised by, or working with, a PCP. These providers qualify for transition of care coverage only if they are credentialed and individually contracted.

Once approved for transition-of-care coverage due to a provider or facility becoming inactive, the care period is the earlier of:

- The termination of the course of treatment by the covered person or the treating provider
- Ninety days after the effective date of your provider's departure or termination, unless the medical director determines that a longer period is necessary
- The date that care is successfully transitioned to the in-network provider
- Benefit limitations under the plan are met or exceeded
- Care is no longer necessary

Discharge planning

Proactive discharge planning is a process that anticipates your needs prior to discharge from an inpatient care setting. It provides the right transition plan from the inpatient setting to the next level of care and addresses your entire care. The process begins at the time of notification and may include the hospital (or other alternate care provider, health plan, other health care providers, the treating practitioner), you, and your family or caregiver. The staff finds and refers potential quality-of-care needs and patient safety events for more review during the discharge planning process.

The discharge plan considers your:

- Age
- Prior level of functioning
- Past medical history
- Anticipated discharge location
- Current medical condition, including diagnosis
- Current level of functioning
- Family and community support
- Psychosocial factors
- Potential barriers to discharge planning

The discharge plan may include:

- Identifying eligible members for referral to covered specialty programs
- Coordinating a variety of services or benefits to be used upon discharge (such as a transfer to inpatient skilled nursing, sub-acute care or a rehabilitation facility, or arranging for home health care, community services, or durable medical equipment)

Changing your primary care provider (PCP)

You can change your designated PCP at any time. Just call the number on your Aetna® member ID card. Or visit your member website.

Provider termination

Our provider contracts with participating providers and facilities ensure a seamless transition in the event the contract ends. Our providers agree to continue services to our members for a limited time after termination in certain circumstances.

When we terminate a PCP from the network, we send a letter to inform you. We also help members select a new PCP or practice site.

When a specialist no longer participates in our network, we inform members who see the specialist regularly by letter. The letter instructs you to ask your PCP to refer you to another in-network specialist. The letter also provides instructions for requesting continuation of care.

The hold-harmless provision

Our contracts contain a hold-harmless provision. This prevents network providers from balance billing members in the event of the insurer's insolvency or inability to continue operations.

Aetna complies with applicable federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, sexual orientation, age or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030 Fresno, CA 93779), **1-800-648-7817**, **TTY: 711, Fax: 859-425-3379** (CA HMO customers: **860-262-7705**), **CRCoordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019**, **1-800-537-7697 (TDD)**.

TTY:711

English	**To access language services at no cost to you, call the number on your ID card.**
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Amharic	የ ቋንቋ አገ ልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለወን ቁጥር ይደውሉ፡ ፡
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة تعريفك.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره درج شده روی کارت شناسایی خود تماس بگیرید.
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obụla, kpọọ nọmba nọ na kaadi njirimara gị
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Yoruba	Láti ráyèsí àwọn iṣẹ́ èdè fún ọ lọ́fẹ̀ẹ́, pe nọ́mbà tó wà lórí káàdì ìdánimọ̀ rẹ.

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