Denver Health Medicare Select HMO

Summary of Benefits

January 1, 2019-December 31, 2019

This information is not a complete description of benefits. Contact the plan for more information. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. To get a complete list of services we cover, please request the "Evidence of Coverage."

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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 **Denver Health Medicare Select HMO)**.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Denver Health Medicare Select (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 https://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 https://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.

Sections in this booklet

- Things to Know About **Denver Health Medicare Select (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

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

If you speak Spanish, language assistance services, free of charge are available to you. Please call our customer service number at 1-877-956-2111. TTY/TDD should call 711. Our hours of operation are 8:00 am - 8:00 pm, 7 days a week.

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Para obtener más información llámenos al 1-877-956-2111. TTY/TDD 711. Los usuarios de TTY/TDD deben llamar al 711. Nuestro horario de atención es de 8 a. m. a 8 p. m. los siete días de la semana.

Things to Know About Denver Health Medicare Select (HMO)

Denver Health Medical Plan, Inc. is a Medicare-approved HMO plan. Enrollment in a Denver Health Medical Plan depends on contract renewal.

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Mountain time.
- From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Mountain time.
- If you are a current or non-member we can be reached at toll-free 1-877-956-2111. TTY/TDD users should call 711.

Who can join?

To join **Denver Health Medicare Select (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following county in Colorado: **Denve**r

Which doctors, hospitals, and pharmacies can I use?

Denver Health Medicare Select (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. You must generally use the network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider/pharmacy directory at our website (www.denverhealthmedicalplan.org).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, 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.

We cover Part D drugs. In addition, we 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.denverhealthmedicalplan.org
- Or, call us and we will send you a copy of the formulary.

SECTION II - SUMMARY OF BENEFITS

How will I determine my drug costs?

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

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 that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

How much is the monthly premium?	$32.00 per month. In addition, you must continue to pay your Medicare Part B premium.
How much is the deductible?	This plan has deductibles for some hospital and medical services, and Part D prescription drugs. The deductible for 2019 in Part B is $185. $375 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 6 which are excluded from the deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $5,500 for services you receive from in-network providers If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost 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.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Covered Medical And Hospital Benefits

Note:

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and copayments/coinsurance may change on January 1 of each year.

- Services with a 1 may require prior authorization.
- Services with a 2 may require a referral from your doctor.

SECTION II - SUMMARY OF BENEFITS	
Inpatient Hospital Care [1,2]	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days per benefit period for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days per benefit period. Days 1-5: $300 per day, this will apply on day of discharge Days 6-90: $0 per day Days 91-150: $578 per lifetime reserve days *Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.*
Outpatient Hospital service [1,2]	We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. 20% of the cost for each Medicare-covered outpatient hospital facility visit • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital ($0 Dollar copay for Covered laboratory services) • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself *Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.*
Doctor's Office Visits [1,2]	Primary care physician visit: $10 copay Specialist visit [1,2]: $30 copay

SECTION II - SUMMARY OF BENEFITS	
Preventive Care	You pay nothing Our plan covers many preventive services, including • Abdominal aortic aneurysm screening • Alcohol misuse counseling and screening • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • Diabetes self-management training • Health and wellness education programs • HIV screening • Immunizations, including Flu shots, Hepatitis B shots, Pneumococcal shots • Lung cancer screening (LDCT) • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$80 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Urgently Needed Services	$40 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for urgently needed services. See the "Inpatient Hospital Care" section of this booklet for other costs.
Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may be different if received in an outpatient surgery setting)*[1,2]	Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost [1,2] Diagnostic tests and procedures: 20% of the cost [1,2] Lab services: 0% of the cost [1,2] Outpatient x-rays: 20% of the cost [1,2] Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost. [1,2]
Hearing Services	Exam to diagnose and treat hearing and balance issues: $30 copay Routine Hearing exam (for up to 1 every three years): $30 copay Hearing aid fitting/evaluation (for up to 1 every three years): $30 copay Hearing aid: $0 copay Our plan pays up to $1,500 every three years for hearing aids.

SECTION II - SUMMARY OF BENEFITS	
Dental Services	In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover the listed dental services, subject to Delta Dental Processing Policies, limitations, and exclusions. All claims are subject to dental consultant review: • Cleanings (Up to 2 per calendar year) • D1110, D4355 • Periapical x-rays (up to 4 per calendar year) • D0220, D0230 • Bitewing x-rays (one set of four per calendar year) • D0274 • Full Mouth X-Rays (Every 36 months) • D0210 or D0330, but not both. • Select oral exams (up to 2 exams per calendar year) • D0120, D0140, and D0150 • Diagnostic Services (up to 2 per calendar year) • D0603 • Fillings (up to 2 listed services per calendar year) • D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 • Periodontics (one every three years) • D4355 • Extractions (unlimited) • D7140, D7210 $0 copay for all covered services. No deductible.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $30 copay Routine eye exam (for up to 1 every year): $30 copay Contact lenses: $0 copay Eyeglasses (frames and lenses) (for up to 1 every year): $0 copay Eyeglasses or contact lenses after cataract surgery: $0 copay Our plan pays up to $250 every benefit year for contact lenses and eyeglasses (frames and lenses).

SECTION II - SUMMARY OF BENEFITS	
Mental Health Care [1.2]	Inpatient Visit [1, 2]: 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 services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days per benefit period for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days per benefit period. *Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.* Days 1-5: $300 per day, this will apply on date of discharge Days 6-90: $0 per day Days 91-150: $578 per lifetime reserve days Outpatient[2]: Outpatient group therapy visit: $10 copay Outpatient individual therapy visit: $10 copay
Skilled Nursing Facility (SNF) [1,2]	Our plan covers up to 100 days in a SNF In 2019, the amounts are: • You pay nothing for days 1 through 20 • $170.50 copay per day for days 21 through 100
Physical Therapy [1,2]	$10 copay
Ambulance	20% of the cost If you are admitted to the hospital, you do not have to pay for the ambulance services.

SECTION II - SUMMARY OF BENEFITS	
Transportation [1]	You pay nothing 25 round trip(s) to plan-approved location every year
Medicare Part B Drugs [1]	For Part B drugs such as chemotherapy drugs [1] : 20% of the cost Other Part B drugs [1] : 20% of the cost
Outpatient Rehabilitation [1,2]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): 20% of the cost Occupational therapy visit: $30 copay Physical therapy and speech and language therapy visit: $10 copay.

Additional Benefits	
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 copay
Diabetes Supplies and Services [1]	Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost Diabetic glucometers and test strips are limited to Trividia Health Products (Glucometers and test strips made by other manufacturers require an organizational determination)
Home Health Care [1,2]	You pay nothing Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. *You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.*
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Outpatient Substance Abuse [1,2]	Group therapy visit: $10 copay Individual therapy visit: $10 copay
Outpatient Surgery [1,2]	Ambulatory surgical center: 20% of the cost Outpatient hospital: 20% of the cost
Prosthetic Devices *(braces, artificial limbs, etc).* [1]	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost
Renal Dialysis [1,2]	20% of the cost

Prescription Drug Benefits	
Initial Coverage Stage	After you pay your yearly deductible of $375, you pay the following cost sharing as seen in the charts below until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. For more information, call us at 303-602-2111 or at 1-877-956-2111. 711 for TTY/TDD users, or you can access our Evidence of Coverage online.

Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$4 copay	$8 copay
Tier 2 (Generic)	$10 copay	$20 copay
Tier 3 (Preferred Brand)	25% coinsurance	25% coinsurance
Tier 4 (Non-Preferred Brand)	50% coinsurance	50% coinsurance
Tier 5 (Specialty Tier)	25% coinsurance	25% coinsurance
Tier 6 (Select Care Drug)	$0 copay	$0 copay

Standard Mail Order Cost-Sharing

Tier	Three-month supply
Tier 1 (Preferred Generic)	$8 copay
Tier 2 (Generic)	$20 copay
Tier 3 (Preferred Brand)	25% coinsurance
Tier 4 (Non-Preferred Brand)	50% coinsurance
Tier 5 (Specialty Tier)	25% coinsurance
Tier 6 (Select Care Drug)	$0 copay

Prescription Drug Benefits	
Initial Coverage Stage Continued	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 and pay the same as an in-network pharmacy, but you will get less of the drug. This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.denverhealthmedicalplan.org on the web. Different out-of-pocket costs may apply for people who: -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) Providers. Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Denver Health Medicare Select (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Denver Health Medicare Select (HMO) approves the exception, you will pay Tier 4 (Non-Preferred Brand)
Coverage Gap Stage	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,820. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap. For more information, call us at 303-602-2111 or at 1-877-956-2111. 711 for TTY/TDD users, or you can access our Evidence of Coverage online.
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: • 5% of the cost, or • $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 co-payment for all other drugs. For more information, call us at 303-602-2111 or at 1-877-956-2111. 711 for TTY/TDD users, or you can access our Evidence of Coverage online.

Denver Health Medical Plan, Inc. and Denver Health Medicare Choice/Select, hereinafter collectively referred to as the "Company," complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company

- Provides free aids and services to people with disabilities to communicate effectively with us , such as:
  - ° Qualified sign language interpreters
  - ° 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 believe that the Company 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 the Company's Grievance and Appeal Department at 938 Bannock Street, Mail Code 6000, Denver, CO 80204, telephone 303-602-2261. You can file a grievance by mail or telephone. If you need help filing a grievance, the Grievance and Appeal Specialist is available to help you.

You can also file a civil right 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: 800-537-7697

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

Denver Health Medical Plan, Inc. y Denver Health Medicaid Choice/Select, en adelante denominados colectivamente la "Compañía", cumplen con las leyes federales aplicables de derechos civiles y no discriminan por motivos de raza, color, nacionalidad, edad, discapacidad ni sexo. La Compañía no excluye a las personas ni las trata de forma diferente debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

La Compañía

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - ° Intérpretes de lenguaje de señas capacitados.
  - ° Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
  - ° Intérpretes capacitados.
  - ° Información escrita en otros idiomas.

Si considera que la Compañía no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja ante el Departamento de Apelaciones y Quejas (Grievance and Appeal Department) de la Compañía, en 938 Bannock Street, Mail Code 6000, Denver, CO 80204, teléfono 303-602-2261. Puede presentar el reclamo por correo postal o teléfono. Si necesita ayuda presentar una queja, un especialista en apelaciones y quejas está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

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: 800-537-7697

Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.

Medicare Select HMO. tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính. [Name of covered entity] không loại trừ mọi người hoặc đối xử với họ khác biệt vì chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Medicare Select HMO.:

- Cung cấp dịch vụ hỗ trợ miễn phí cho những người khuyết tật để giao tiếp với chúng tôi có hiệu quả, như:
  - ° Thông dịch viên ngôn ngữ ký hiệu đủ năng lực
  - ° Thông tin bằng văn bản ở các định dạng khác (chữ in lớn, âm thanh, định dạng điện tử có thể tiếp cận, các định dạng khác
- Cung cấp miễn phí các dịch vụ ngôn ngữ cho những người có ngôn ngữ chính không phải là tiếng Anh, như:
  - ° Thông dịch viên đủ năng lực
  - ° Thông tin được trình bày bằng ngôn ngữ khác

Nếu bạn cần những dịch vụ này, hãy liên hệ Rocky Mountain Region Nếu bạn tin rằng Medicare Select HMO. không cung cấp những dịch vụ này hoặc phân biệt đối xử theo cách khác dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính, bạn có thể nộp đơn khiếu nại với: Company's Grievance and Appeal Department at 938 Bannock Street, Mail Code 6000, Denver, CO 80204, telephone 303-602-2261. Bạn có thể trực tiếp nộp đơn khiếu nại hoặc gửi qua đường bưu điện, chuyển fax, hoặc email. Nếu bạn cần trợ giúp nộp đơn khiếu nại, Grievance and Appeal Department sẵn sàng giúp bạn.

Bạn cũng có thể nộp đơn khiếu nại về dân quyền lên U.S. Department of Health and Human Services (Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ), Office for Civil Rights (Văn Phòng Dân Quyền) bằng

hình thức điện tử qua Office for Civil Rights Complaint Portal, có trên trang https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, hoặc qua đường bưu điện hoặc bằng điện thoại tại:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
800-537-7697 (TDD)

Các mẫu khiếu nại có trên trang http://www.hhs.gov/ocr/office/file/index.html.

Multi-language Interpreter Services

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-877-956-2111 (TTY/TDD: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-956-2111 (TTY/TDD: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-956-2111 (TTY: 711).

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1-877-956-2111（TTY：711）

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-956-2111 (TTY: 711)번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-956-2111 (телетайп: 711).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-877-956-2111 (**መስማት ለተሳናቸው**: 711).

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات اللغوية المساعدة تتوافر لك بالمجان. برقم اتصل 1-877-956-2111 (711). :والبكم الصم هاتف رقم(

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-956-2111 (TTY: 711).

ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-877-956-2111 (ATS : 711).

ध्यान दिनुहोसः तपयाईले नेपयाली बोलनुहन्छु भने तपयाईंको ननम्त भयाषया सहयात्तया सवे याहरू ननःशुलक रूपमया उपलब्ध ्छ। फोन गनुहोस ् 1-877-956-2111 (दिदिवयार्ः 711)।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-956-2111 (TTY: 711).

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。1-877-956-2111（TTY: 711）まで、お電話にてご連絡ください。

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-956-2111 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-956-2111)TTY: 711(تماس بگیرید.

Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jŭ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá 1-877-956-2111 (TTY:711)

Ntị: Ọ bụrụ na asụ Ibo, asụsụ aka ọasụ n'efu, defu, aka. Call 1-877-956-2111)TTY: 711(.

AKIYESI: Bi o ba nsọ èdè Yorùbú ọfé ni iranlọwọ lori èdè wa fun yin o. Ẹ pe ẹrọ-ibanisọrọ yi 1-877-956-2111 (TTY: 711).