



Aetna Life Insurance Company
PO Box 14876
Lexington KY 40512-4876

SANDRA AMARAL
6 CATALINA AVE
SALINAS, CA 93901

09/29/2023

Member Name: SANDRA AMARAL
Member ID: W278375968
Member Date of Birth: 02/23/1972
Reference Number: 230920076309
Plan Sponsor: PGP INTERNATIONAL, INC.
Plan Sponsor Account Number: 193609

Dear Member and Healthcare Provider(s) of Record,

After review, we have made a decision about coverage for the following health care services for the member named above. We use nationally recognized clinical guidelines and resources, such as MCG criteria and Clinical Policy Bulletins. Clinical Policy Bulletins are available at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>, applicable state guidelines when required, and benefit plan documents to support these coverage decisions.

Coverage Decisions For Denied Services:

Providers: TOTAL LIPEDEMA CARE
TLC SURGICAL CENTER

Service Dates:	Procedure Code:	Service Description:	Number:	Type of Service:
09/29/2023 - 09/29/2024	15839	EXCISION EXCESSIVE SKIN & SUBQ TISSUE OTHER AREA	2	Time(s)

Coverage for this service has been denied for the following reason(s):

We reviewed information received about your condition and circumstances. We used the Clinical Policy Bulletin (CPB): Abdominoplasty, Suction Lipectomy and Ventral Hernia Repair. Based on CPB criteria and the information we have, we are denying coverage for the requested panniculectomy (taking off the skin fold at the bottom of the abdomen). You do not meet both of the following criteria: (1) photographs show the skin fold hangs below the pubic bone at the bottom of your abdomen, and (2) photographs with your abdominal fold lifted confirm the fold is causing a chronic skin inflammation, infection or chafing that even with treatment (such as pills, creams, lotions or powders) does not stay better over a 3 month period.

(Medical Necessity Denial) This coverage denial was based on the terms of the member's benefit plan document (such as the Certificate of Coverage or benefit plan booklet/handbook, including any amendments or riders). The plan does not cover services that are not Medically necessary. Please see the reference to non-Medically necessary services listed in the Exclusions section of the benefit plan document or refer to the description of Medically necessary services in the Definitions or Glossary section of the benefit plan document.

Providers: TOTAL LIPEDEMA CARE
TLC SURGICAL CENTER

Service Dates:	Procedure Code:	Service Description:	Number:	Type of Service:
09/29/2023 - 09/29/2024	15877	SUCTION ASSISTED LIPECTOMY TRUNK	1	Time(s)

Coverage for this service has been denied for the following reason(s):

We reviewed information received about your condition and circumstances. We used the Clinical Policy Bulletin (CPB): Abdominoplasty, Suction Lipectomy, and Ventral Hernia Repair. Based on CPB criteria and the information we have, we're denying coverage for a liposuction surgery for lipedema of your abdomen. The requirement for coverage is documentation that your pain and tenderness hasn't improved after at least three months of conservative treatment with weight loss programs. You don't meet this requirement.

(Medical Necessity Denial) This coverage denial was based on the terms of the member's benefit plan document (such as the Certificate of Coverage or benefit plan booklet/handbook, including any amendments or riders). The plan does not cover services that are not medically necessary. Please see the reference to non-medically necessary services listed in the Exclusions section of the benefit plan document or refer to the description of medically necessary services in the Definitions or Glossary section of the benefit plan document.

Coverage Decisions For Approved Services:

Providers: TOTAL LIPEDEMA CARE

Service Dates:	Procedure Code:	Service Description:	Modifier Code*:	Number:	Type of Service:
09/29/2023 - 09/29/2024	15879	SUCTION ASSISTED LIPECTOMY LOWER EXTREMITY	50	4	Time(s)

*50: Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

Coverage for this service has been approved, subject to requirement in this letter.

This service is approved at an in-network benefit level. The provider identified to provide this service participates with this plan. The member will be responsible only for in-network cost-sharing requirements.

Providers: TLC SURGICAL CENTER

Service Dates:	Procedure Code:	Service Description:	Modifier Code*:	Number:	Type of Service:
09/29/2023 - 09/29/2024	15879	SUCTION ASSISTED LIPECTOMY LOWER EXTREMITY	50	4	Time(s)

*50: Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

Coverage for this service has been approved, subject to requirement in this letter.

This service is approved at an out-of-network benefit level. The provider identified to provide this service does not participate with this plan. The member will be responsible for out-of-network cost-sharing requirements and for any difference between the provider's charge and the amount the plan covers.

Providers: TLC SURGICAL CENTER

Service Dates:	Procedure Code:	Service Description:	Modifier Code*:	Number:	Type of Service:
09/29/2023 - 09/29/2024	15832	EXCISION EXCESSIVE SKIN & SUBQ TISSUE THIGH	50	1	Time(s)

*50: Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5

digit code.

Coverage for this service has been approved, subject to requirement in this letter.

This service is approved at an out-of-network benefit level. The provider identified to provide this service does not participate with this plan. The member will be responsible for out-of-network cost-sharing requirements and for any difference between the provider's charge and the amount the plan covers.

Providers: TOTAL LIPEDEMA CARE

Service Dates:	Procedure Code:	Service Description:	Modifier Code*:	Number:	Type of Service:
09/29/2023 - 09/29/2024	15832	EXCISION EXCESSIVE SKIN & SUBQ TISSUE THIGH	50	1	Time(s)

*50: Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

Coverage for this service has been approved, subject to requirement in this letter.

This service is approved at an in-network benefit level. The provider identified to provide this service participates with this plan. The member will be responsible only for in-network cost-sharing requirements.

Providers: TLC SURGICAL CENTER

Service Dates:	Procedure Code:	Service Description:	Modifier Code*:	Number:	Type of Service:
09/29/2023 - 09/29/2024	15836	EXCISION EXCESSIVE SKIN & SUBQ TISSUE ARM	50	1	Time(s)

*50: Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

Coverage for this service has been approved, subject to requirement in this letter.

This service is approved at an out-of-network benefit level. The provider identified to provide this service does not participate with this plan. The member will be responsible for out-of-network cost-sharing requirements and for any difference between the provider's charge and the amount the plan covers.

Providers: TOTAL LIPEDEMA CARE

Service Dates:	Procedure Code:	Service Description:	Modifier Code*:	Number:	Type of Service:
09/29/2023 - 09/29/2024	15836	EXCISION EXCESSIVE SKIN & SUBQ TISSUE ARM	50	1	Time(s)

*50: Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

Coverage for this service has been approved, subject to requirement in this letter.

This service is approved at an in-network benefit level. The provider identified to provide this service participates with this plan. The member will be responsible only for in-network cost-sharing requirements.

Providers: TLC SURGICAL CENTER

Service Dates:	Procedure Code:	Service Description:	Number:	Type of Service:
09/29/2023 - 09/29/2024	15877	SUCTION ASSISTED LIPECTOMY TRUNK	4	Time(s)

Coverage for this service has been approved, subject to requirement in this letter.

This service is approved at an out-of-network benefit level. The provider identified to provide this service does not participate with this plan. The member will be responsible for out-of-network cost-sharing requirements and for any difference between the provider's charge and the amount the plan covers.

Providers: TOTAL LIPEDEMA CARE

Service Dates:	Procedure Code:	Service Description:	Number:	Type of Service:
09/29/2023 - 09/29/2024	15877	SUCTION ASSISTED LIPECTOMY TRUNK	4	Time(s)

Coverage for this service has been approved, subject to requirement in this letter.

This service is approved at an in-network benefit level. The provider identified to provide this service participates with this plan. The member will be responsible only for in-network cost-sharing requirements.

Providers: TOTAL LIPEDEMA CARE

Service Dates:	Procedure Code:	Service Description:	Number:	Type of Service:
09/29/2023 - 09/29/2024	15878	SUCTION ASSISTED LIPECTOMY UPPER EXTREMITY	2	Time(s)

Coverage for this service has been approved, subject to requirement in this letter.

This service is approved at an in-network benefit level. The provider identified to provide this service participates with this plan. The member will be responsible only for in-network cost-sharing requirements.

Providers: TLC SURGICAL CENTER

Service Dates:	Procedure Code:	Service Description:	Number:	Type of Service:
09/29/2023 - 09/29/2024	15878	SUCTION ASSISTED LIPECTOMY UPPER EXTREMITY	2	Time(s)

Coverage for this service has been approved, subject to requirement in this letter.

This service is approved at an out-of-network benefit level. The provider identified to provide this service does not participate with this plan. The member will be responsible for out-of-network cost-sharing requirements and for any difference between the provider's charge and the amount the plan covers.

Summary of Covered Services:

Service Code(s) and Description:

15832 EXCISION EXCESSIVE SKIN & SUBQ TISSUE THIGH

*50: Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

Total Previous Services Covered	Total Services Covered
0.00	1.00

Summary of Covered Services:

Service Code(s) and Description:

15836 EXCISION EXCESSIVE SKIN & SUBQ TISSUE ARM

*50: Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are

performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

Total Previous Services Covered	Total Services Covered
0.00	1.00

Summary of Covered Services:

Service Code(s) and Description:

15877 SUCTION ASSISTED LIPECTOMY TRUNK

Total Previous Services Covered	Total Services Covered
1.00	4.00

Summary of Covered Services:

Service Code(s) and Description:

15878 SUCTION ASSISTED LIPECTOMY UPPER EXTREMITY

Total Previous Services Covered	Total Services Covered
1.00	2.00

Summary of Covered Services:

Service Code(s) and Description:

15879 SUCTION ASSISTED LIPECTOMY LOWER EXTREMITY

*50: Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

Total Previous Services Covered	Total Services Covered
1.00	4.00

Coverage Approvals:

For the services identified above for which coverage has been approved, all three components of our coverage approval process have been satisfied:

- Verification of the member's eligibility for coverage under the plan; and
- Verification that the plan provides coverage for the type of services approved (but, has not

verified whether any applicable dollar limits under the plan have been exhausted, or will soon be exhausted); and

- Verification the approved services meet medical necessity criteria.

Validity of this coverage approval is subject to all those components being satisfied at the time the approved services are actually provided. This coverage approval is NOT effective and benefits may not be paid if:

1. the member's health condition changes materially before the approved services are provided, so that the approved treatment/services no longer meet medical necessity criteria due solely to the member's materially changed health condition; OR
2. for precertification:
 - (1) the specific dates of the approved services (the "from" and "through" dates identified in this letter) have passed or
 - (2) for scheduled services (services planned but not yet received), the approved services have not been provided within six months from the date of this letter; OR
3. there was a material misrepresentation or omission of clinical information about the member at the time of the coverage approval or that there was fraud with respect to the approved services; OR

If the approved services are to be delivered more than thirty (30) calendar days from the date of this letter, this coverage approval is only valid if the provider contacts us and confirms the coverage approval five (5) business days prior to the date of service.

To avoid delay or denial of claim payment for scheduled services, please notify us if the planned date(s) of service or other circumstances regarding the approved services change, or if any additional services are needed beyond those approved. Reimbursement will be based on standard coding and bundling logic and any mutually agreed upon contracted or negotiated rates, subject to any and all copays or coinsurance requirements. If the actual procedure/service or service dates on the claim differ from the information we have at this time, there may be a delay or denial in claim processing.

If you plan to receive services from a participating (in-network) provider or facility, remember to confirm that your provider/facility still participates with your plan prior to getting your care. You can do this by using the provider search feature on the member website. Call Member Services at the number on your ID card if you need help or have questions.

No Coverage Financial Sanctions Exclusion Disclaimer

If you travel to a country sanctioned by the United States, the plan cannot provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we cannot pay for services from that provider. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan cannot pay for those services. For more information, Visit

Member Out-of-Network Information: If You Receive Your Care From an Out-of-Network Provider:

Your plan has out-of-network benefits. If you use out-of-network providers, here's what you should know:

We may process your claims as "out-of-network" or "non-preferred." And, you may have to pay:

- Higher copayments
- Deductibles
- Coinsurance
- Any provider charges above what we cover (these costs may be high)

Sometimes, an out-of-network provider may treat you, even if the facility or other doctors are in-network. Here's an example. You go to an in-network surgeon, but his or her assistant isn't in-network. In that case, you may be responsible for higher charges.

Save money—use in-network providers

To save money and get the most out of your plan:

- Use in-network providers.
- Get approval for your highest benefit level from us before using out-of-network providers.
- Find out (in advance) if all providers who give you care are in-network by using provider search on your secure member website.

What you should do in an emergency

Of course, in an emergency, you should go to the closest doctor or hospital. We'll cover the visit, even if the provider is out-of-network.

Have questions? We're here to help.

- Refer to your health plan documents.
- Visit your secure member website.

Non-Par Providers: Effective 01/01/2022, claims for services must be filed within 12 months from the date of service.

Information About Coverage Denials:

"Coverage" means whether or not a service or treatment is covered under the terms of the member's benefit plan or payable under the terms of the provider's agreement.

Our decision is limited to whether the health care services are covered under the member's benefit plan or provider agreement. The treating practitioner, in consultation with the member, remains responsible for deciding what treatment is appropriate and what services to provide.

The clinical criteria upon which this decision was based are available free of charge upon request by calling our Member Services department using the phone number displayed on the member's ID card.

Denial codes are not used and therefore not available.

Member billing by participating (in-network) providers (doctor or facility): If your care by a participating provider is denied based on medical necessity, the provider is not allowed to bill you for the denied services unless you knew in advance that the services would not be covered and you agreed in writing to pay for them.

Member Appeal Rights:

You may not agree with our decision. You or someone you choose to act for you (called your authorized representative) can ask us for a review (appeal). Do this by phone or in writing within 180 days (6 months) after you receive this letter. Some plans give more than 180 days to do this. See your plan brochure or other plan document, such as your Certificate of Coverage or your Summary Plan Description.

How to ask for an appeal by phone

Call Member Services. The toll-free telephone number is listed on your member ID card. If you are hearing impaired you can call 711 for Telecommunication Relay Services (TRS). Member Services can also help you with the process of naming an authorized representative.

How to ask for an appeal in writing

You or your authorized representative can send a letter or a completed Member Complaint and Appeal Form to the address below. The form is online at:
<https://member.aetna.com/memberSecure/assets/pdfs/forms/68192.pdf>

Aetna
Individual, Small Group and Middle Market (ISM) CRT
P.O. Box 14002
Lexington, KY 40512

Your request should include:

- Your name;
- Your member ID number (or date of birth) or other identifying information;
- The group's name (for example, if you are covered by your employer);
- Comments, documents, records and other information you want us to consider.

You may also ask us for documents that are relevant to the unfavorable decision for your review. These are free. Call Member Services to ask for them. The toll-free telephone number is listed on your member ID card.

In general, one level of internal appeal is available under health plans providing coverage for

individuals, and two levels of internal appeal are available under plans covering employees of an employer.

ONE-LEVEL APPEAL PROCESS

If your plan offers a single appeal and your appeal is pre-service (this means you need approval for coverage before you receive medical care), we will send you a decision within 30 days after we receive your request. For post service appeal requests, we will send you a decision within 60 days after we receive your request.

If your appeal is urgent (one where you or your doctor believes a delay in making a decision could seriously jeopardize your life, health or ability to regain maximum function, or could subject you severe pain), you, your doctor or other authorized representative can request an expedited (faster) review. To do this call the National Clinical Appeal Unit expedited appeal toll-free number at 1-877-665-6736. You can also fax your request to 1-860-754-5321.

The National Clinical Appeal Unit will document phone requests in writing. We will give you a decision within 72 hours after we receive your request for review. If your appeal is urgent, you may also request an expedited external review at the same time as the internal appeal.

TWO-LEVEL APPEAL PROCESS

If your plan provides for two appeals and your appeal is pre-service (this means you need approval for coverage before you receive medical care), we will send you a decision within 15 days after we receive your request. For post-service appeal requests, we will send you a decision within 30 days after we receive your request. In either case, if you do not agree with the decision you have the right to file a second request for appeal. To do this, call or write to us within 60 days from the date that you receive the first appeal decision.

If your appeal is urgent (one where you or your doctor believes a delay in making a decision could seriously jeopardize your life, health or ability to regain maximum function, or could subject you to severe pain in the opinion of your physician), you, your doctor or your authorized representative can request an expedited (faster) review. To do this call the National Clinical Appeal Unit expedited appeal toll-free number at 1-877-665-6736. You can also fax your request to 1-860-754-5321.

The National Clinical Appeal Unit will document phone requests in writing. We will give you a decision within 36 hours after we receive your request for review. If your appeal is urgent, you may also request an expedited external review at the same time as the internal appeal.

The Consumer Communications Bureau with the California Department of Insurance is available to assist customers with claims they feel have been wrongfully denied or rejected. Consumers may call or write to the Bureau to have claims reviewed.

Callers outside California and those in California (area codes 213 or 310) may contact the Consumer Communications Bureau at 1-213-897-8921. The number for the rest of California is

1-800-927-4357. The mailing address is Consumer Communications Bureau, California Department of Insurance, 300 S. Spring Street, Los Angeles, CA 90013. The Web site is www.insurance.ca.gov.

If you have a grievance against your insurance company, you should first telephone your plan at the number shown on your enrollment card and use the insurance company's grievance process before contacting the Department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your insurance company, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. The plan's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

After your appeal, if we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review by an independent third party, who will review our decision and make a final decision.

Independent medical review of grievances involving a disputed health care service

You may request an independent medical review (IMR) of disputed health care services from the California Department of Insurance (Department) if you believe that health care services have been improperly denied, modified, or delayed by the insurance company or one of its contracted providers. A "disputed health care service" is any health care service eligible for coverage and payment under your subscriber contract that has been denied, modified, or delayed by the insurance company or one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. Aetna provides an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the insurance company regarding a disputed health care service.

Eligibility: Your application for IMR will be reviewed by the Department to confirm that: (1)(A) Your provider has recommended a health care service as medically necessary, or (B) You have received urgent care or emergent services that a provider determined was medically necessary, or (C) You have been seen by a contracting provider for the diagnosis or treatment of the medical condition for which you seek independent review; (2) The disputed health care service has been denied, modified, or delayed by the insurance company or one of its contracted providers, based in whole or in part on a decision that the health care service is not medically necessary; and (3) You have filed a grievance with the insurance company or its contracted providers and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review, you may bring it immediately to the Department's attention. In

addition, the Department may waive the requirement that you follow the insurance company's grievance process for any period of time in extraordinary and compelling cases. For urgent care, you may not be required to participate in the insurance company's grievance process for more than 3 days before accessing IMR.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, the insurance company will provide the health care service. For non-urgent cases, the IMR organization designated by the Department must provide its determination in 30 days of receipt of your application and supporting documents. For urgent cases involving imminent and serious threat to your health, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, the IMR organization must provide its determination within 3 business days.

When filing a request for an Independent Medical Review, you will be required to authorize release of any medical records that may be needed for the purpose of reaching a decision.

You have six months after you receive our final unfavorable decision to request an external review.

In urgent care situations, you may request a faster external review by calling 1-877-848-5855.

If you do not agree with the final decision you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

We Protect Your Privacy:

Protecting the privacy of member health information is a top priority. When contacting us about this Notice or for help with other questions, please be prepared to provide member name, member ID number, and date of birth.

Patient Safety Information:

To learn more about patient safety and hospitals, please log on to The Leapfrog Group's website at <http://www.leapfroggroup.org/>. This site will give you information about hospitals that have met specific safety standards. For participating hospitals, the same information can be accessed on your secure member website using provider search.

Your provider may have sent diagnosis codes with your request for authorization of services. If you wish to obtain these codes and their descriptions, call us at the Member Services number on your medical identification card. If you have medical questions about your diagnosis, contact your provider.

If you suspect fraud or abuse involving your health benefits, please call the toll free Hotline at 1-800-338-6361 or contact us by E-Mail at AetnaSIU@Aetna.com.

Member Services: If you, your authorized representative or your health care providers need help with filing an appeal or complaint or would like additional information about this decision, call the toll-free Member Services number on the member's identification card.

We hope this information has answered your coverage questions. Member Services representatives are available to help health care professionals, members and their authorized representatives with any questions about eligibility, plan benefits, claims and coverage decisions. If you, your authorized representative or your health care providers of record have additional questions or would like to request copies of documents related to the coverage decision, call the toll-free Member Services number on your member ID card.

Need help understanding this notice or our decision? Call us free of charge at the 1-800 number on your medical ID card. There are also other resources available to help you. Most plans are now subject to health care reform law. Call us or ask your employer if your plan is subject to the law. If it is, you can also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) for help, if your health plan is provided by your employer. In addition, a consumer assistance program may be available to assist you.

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street South Tower
Los Angeles CA 90013
1-800-927-Help (4357)
1-800-482-4833 (TTY)
<http://www.insurance.ca.gov>

For questions about appeal rights, this notice, or for more assistance, you may contact:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street South Tower
Los Angeles CA 90013
1-800-927-Help (4357)
1-800-482-4833 (TTY)
www.insurance.ca.gov

Sincerely,



Jordan Pritzker MD
Medical Director

A copy of this letter is also being sent to:

TOTAL LIPEDEMA CARE
TLC SURGICAL CENTER

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

Aetna
148.32.318.1

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

Aetna provides 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: PO 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, 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.
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
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Armenian	Ձեր նախընտրած լեզվով ավելճար խոսքըդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հեռախոսահամարով
Persian Farsi	برای دسترسی به خدمات زبانی به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
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。
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫੋਨ ਕਰੋ।
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language.

For help, call us at the number listed on your ID card or 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。 您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-287-0117 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-287-0117. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

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Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-877-287-0117. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-877-287- 0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆոռնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-287-0117. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-877-287-

0117までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

برای . میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. خدمات مجانی مربوط به زبان دریافت

کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این 1-877-287-0117 تماس بگیرید . برای دریافت کمک بیشتر، شماره

Insurance of Dept. CA البفرنیا Persian . تلفن کنید 1-800-927-4357 به شماره ((اداره بیمه كاليفرنيا

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ

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សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអាចឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រុមស្តង់ដារភាសាភាសាខ្មែរ

តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-287-0117 . للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية أليفورنيا