aetna®

January 1, 2019

Changes to your prescription drug coverage

There will be changes to the **Aetna Value Plus Plan** drug list that start on **January 1, 2019**. It is important that you review and understand the changes in the chart below. Talk to your health care provider about how these changes might impact you.

How to find a preferred medicine that's right for you
You can visit the website that's on your member ID card and sign in to your account. If you have any questions, you can call us at the toll-free number on your member ID card.

The information in this chart is based on the plan you're currently on at the time of this letter. These changes apply to all plans unless noted*

UPPER CASE = brand-name medication **lower case = generic medication**
*** Changes apply if your plan includes this feature.**

Prescription Drug Change	Change
ABILIFY	Preauthorization has been removed; You must first try 2 of risperidone, quetiapine, ziprasidone, aripirazole, or olanzapine
altacaine	Not covered under pharmacy benefit
altafluor	Not covered under pharmacy benefit
ALTOPREV	You must first try 2 of atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin or rosuvastatin
AMBIEN	You must first try zolpidem, zaleplon or eszopiclone
AMBIEN CR	You must first try zolpidem, zaleplon or eszopiclone
amcinonide	You must first try betamethasone dipropionate

Prescription Drug Change	Change
APEXICON E	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try augmented betamethasone; You can fill up to 60gm/ month
APRISO	You must first try DELZICOL, LIALDA, PENTASA or mesalamine
ASTAGRAF XL	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
ATACAND	You must first try 2 of candesartan, eprosartan, irbesartan, losartan, valsartan, and telmisartan
ATACAND HCT	You must first try 2 of candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, and valsartan/hctz
ATELVIA	You must first try alendronate weekly
AUSTEDO	Must be filled through a specialty network pharmacy
AVALIDE	You must first try 2 of candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, and valsartan/hctz
AVAPRO	You must first try 2 of candesartan, eprosartan, irbesartan, losartan, valsartan, and telmisartan
avidoxy	You must first try minocycline, doxycycline monohydrate or doxycycline hyclate
AVODART	You must first try dutasteride or finasteride
AXERT	You must first try 3 of naratriptan, rizatriptan, sumatriptan, or zolmitriptan
AZASITE	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
AZULFIDINE	You must first try DELZICOL, LIALDA, PENTASA or mesalamine

Prescription Drug Change	Change
AZULFIDINE EN-TABS	You must first try DELZICOL, LIALDA, PENTASA or mesalamine
BENZEFOAM	Not covered under pharmacy benefit
BENZEFOAM ULTRA	Not covered under pharmacy benefit
benzepro	Not covered under pharmacy benefit
benzepro creamy wash	Not covered under pharmacy benefit
benzepro foaming cloths	Not covered under pharmacy benefit
benzepro short contact	Not covered under pharmacy benefit
benzoyl peroxide	Not covered under pharmacy benefit
benzoyl peroxide short co	Not covered under pharmacy benefit
betameth val	You must first try triamcinolone
bio glo	Not covered under pharmacy benefit
BOTOX COSMETIC	Not covered under pharmacy benefit
BP CLEANSING WASH	Not covered under pharmacy benefit
bp foam	Not covered under pharmacy benefit
bp wash	Not covered under pharmacy benefit
bpo 6% foaming cloths	Not covered under pharmacy benefit
CAYSTON	You can fill up to 84 vials/ 56 days
CELEBREX	You must first try 2 generic non steroidal anti-inflammatory drugs
CETROTIDE	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
CLEOCIN-T	You must first try EPIDUO
CLINDAGEL	You must first try EPIDUO
clindamycin gel	You must first try EPIDUO

Prescription Drug Change	Change
clindamycin lot	You must first try EPIDUO
clindamycin sol	You must first try EPIDUO
clobetasol cr	You must first try augmented betamethasone
clobetasol gel	You must first try augmented betamethasone
clobetasol lot	You must first try augmented betamethasone
clobetasol oint	You must first try augmented betamethasone
clobetasol propionate e	You must first try augmented betamethasone
clobetasol sol	You must first try augmented betamethasone
CLOBEX	You must first try augmented betamethasone
cocaine hcl sol 4%	Not covered under pharmacy benefit
COPAXONE INJ 40MG/ML	Non-preferred specialty drug; Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try GLATOPA, glatiramer
coremino	You must first try minocycline, doxycycline monohydrate or doxycycline hyclate
COZAAR	You must first try 2 of candesartan, eprosartan, irbesartan, losartan, valsartan, and telmisartan
CUTIVATE	You must first try triamcinolone
DEBACTEROL	Not covered under pharmacy benefit
DENTAL PRODUCTS brand and generic	Not covered under pharmacy benefit
desonide	You must first try alclometasone
DESOWEN	You must first try alclometasone
desoximetasone	You must first try betamethasone dipropionate
diflorasone diacetate	You must first try augmented betamethasone; You can fill up to 60gm/ month

Prescription Drug Change	Change
DIOVAN	You must first try 2 of candesartan, eprosartan, irbesartan, losartan, valsartan, and telmisartan
DIOVAN HCT	You must first try 2 of candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, and valsartan/hctz
DMT SUIK KIT	Not covered under pharmacy benefit
doxycycline hyclate dr	You must first try minocycline, doxycycline monohydrate or doxycycline hyclate
doxycycline monohydrate	You must first try minocycline, doxycycline monohydrate or doxycycline hyclate
DRITHO-CREME HP	Not covered under pharmacy benefit
DS PREP PAK	Not covered under pharmacy benefit
E-Z-CAT DRY	Not covered under pharmacy benefit
E-Z-DISK	Not covered under pharmacy benefit
E-Z-DOSE ENEMA	Not covered under pharmacy benefit
E-Z-PASTE	Not covered under pharmacy benefit
EHA LOTION 4%	Not covered under pharmacy benefit
ELIDEL	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
ELOCON	You must first try triamcinolone
ENTERO VU	Not covered under pharmacy benefit
EPIPEN 2-PAK	Non-preferred brand drug
EPIPEN-JR 2-PAK	Non-preferred brand drug
EPOGEN	You must first try RETACRIT
ESBRIET	Must be filled through a specialty network pharmacy
ESOMEPRAZOLE STRONTIUM	You must first try 3 generic PPIs, i.e. omeprazole, lansoprazole, pantoprazole or rabeprazole

Prescription Drug Change	Change
ethyl chloride aerosol spray	Not covered under pharmacy benefit
EXFORGE	You must first try amlodipine with any 2 of candesartan, rbesartan, losartan, or telmisartan
EXFORGE HCT	You must first try amlodipine with any 2 of candesartan hctz, losartan and telmisartan hctz
EXJADE	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
EXODERM	Not covered under pharmacy benefit
FARXIGA	Preferred brand drug
FEM PH GEL	Not covered under pharmacy benefit
FEMCON FE	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
fenoprofen calcium	Non-preferred generic drug; Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try 2 generic non steroidal anti-inflammatory drugs; You can fill up to 16 caps/ day
FENORTHO	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try 2 generic non steroidal anti-inflammatory drugs; You can fill up to 16 caps/ day
FLECTOR PATCH	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
fluocinonide cr 0.01%	You must first try alclometasone
fluocinonide cr 0.025%	You must first try triamcinolone
fluocinonide gel 0.05%	You must first try betamethasone dipropionate
fluocinonide oin 0.025%	You must first try triamcinolone

Prescription Drug Change	Change
fluocinonide oin 0.05%	You must first try betamethasone dipropionate
fluor-i-strips a.t.	Not covered under pharmacy benefit
fluorescein-benoxinate	Not covered under pharmacy benefit
fluticasone cre 0.05%	You must first try triamcinolone
FORMA-RAY	Not covered under pharmacy benefit
formadon	Not covered under pharmacy benefit
formaldehyde	Not covered under pharmacy benefit
FOSAMAX PLUS D	You must first try alendronate weekly; When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
FROVA	You must first try 3 of naratriptan, rizatriptan, sumatriptan, or zolmitriptan
FUL-GLO brand and generic	Not covered under pharmacy benefit
GASTROGRAFIN	Not covered under pharmacy benefit
GENERESS FE	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
GLIADEL WAFER	Not covered under pharmacy benefit
glutaraldehyde	Not covered under pharmacy benefit
GRASTEK	Preferred brand drug; Preauthorization required*; You must first try 2 generic antihistamine drugs; You can fill up to 1/ day
halobetasol propionate	You must first try augmented betamethasone
HYZAAR	You must first try 2 of candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, and valsartan/hctz

Prescription Drug Change	Change
INDOCIN SUPPOSITORY	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try 2 generic non steroidal anti-inflammatory drugs; You can fill up to 4 suppositories/ day
INDOCIN SUSPENSION	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try 2 generic non steroidal anti-inflammatory drugs; You can fill up to 16ml/ day
iodine strong	Not covered under pharmacy benefit
JUBLIA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
KALETRA SOL	Non-preferred brand drug
KARBINAL ER	You must first try carbinoxamine
KERALYT	Not covered under pharmacy benefit
lactic acid	Not covered under pharmacy benefit
LATUDA	Non-preferred brand drug; You must first try 2 of risperidone, quetiapine, ziprasidone, aripirazole and olanzapine; When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
LESCOL XL	You must first try 2 of atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin or rosuvastatin
LEVITRA	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
LEXIVA	Non-preferred brand drug
lidocaine and tetracaine	You can fill up to 30mg/month
lidocaine hcl	You can fill up to 50gm/ month

Prescription Drug Change	Change
LIPITOR	You must first try 2 of atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin or rosuvastatin
LIQUID POLIBAR PLUS	Not covered under pharmacy benefit
lugols strong iodine	Not covered under pharmacy benefit
LUNESTA	You must first try zolpidem, zaleplon or eszopiclone
LUPRON DEPOT (1-MONTH)	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
LUPRON DEPOT (3-MONTH)	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
LUPRON DEPOT (4-MONTH)	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
LUPRON DEPOT (6-MONTH)	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
LYRICA	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
MAVYRET	Preferred specialty drug
md-gastroview	Not covered under pharmacy benefit
methadone hcl	You can fill up to 4 tabs/ day
methadose	You can fill up to 4 tabs/ day
METOPIRONE	Not covered under pharmacy benefit
MICARDIS	You must first try 2 of candesartan, eprosartan, irbesartan, losartan, valsartan, and telmisartan
MICARDIS HCT	You must first try 2 of candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, and valsartan/hctz

Prescription Drug Change	Change
minocycline hcl	You must first try minocycline, doxycycline monohydrate or doxycycline hyclate
minocycline hcl er	You must first try minocycline, doxycycline monohydrate or doxycycline hyclate
mometasone furoate	You must first try triamcinolone
MONSELS FERRIC SUBSULFATE	Not covered under pharmacy benefit
NEULASTA	Non-preferred specialty drug; You must first try FULPHILA
NEULASTA ONPRO KIT	Non-preferred specialty drug; You must first try FULPHILA
NEXIUM	You must first try 3 of esomeprazole mag, lansoprazole, omeprazole, pantoprazole or rabeprazole
nitro-time capsules	Not covered under pharmacy benefit
nitroglycerine er capsules	Not covered under pharmacy benefit
NUCORT LOT 2%	Not covered under pharmacy benefit
NUEDEXTA	Preauthorization required*
ODACTRA	Non-preferred brand drug; Preauthorization required*; You must first try 2 generic antihistamine drugs; You can fill up to 1/ day
opium tincture	Not covered under pharmacy benefit
ORALAIR	Non-preferred brand drug; Preauthorization required*; You must first try 2 generic antihistamine drugs; You can fill up to 1/ day
ORALAIR ADULT STARTER PAC	Non-preferred brand drug; Preauthorization required*; You must first try 2 generic antihistamine drugs; You can fill up to 1/ day
ORALAIR CHILDREN/ADOLESCE	Non-preferred brand drug; Preauthorization required*; You must first try 2 generic antihistamine drugs; You can fill up to 1/ day
OVACE PLUS	Not covered under pharmacy benefit

Prescription Drug Change	Change
OVACE PLUS WASH	Not covered under pharmacy benefit
OVACE WASH	Not covered under pharmacy benefit
OXTELLAR XR	You must first try oxcarbazepine
OZURDEX	Not covered under pharmacy benefit; Preauthorization has been removed
PEDI BOOT KIT	Not covered under pharmacy benefit
phenazo	Not covered under pharmacy benefit
phenazopyridine hcl	Not covered under pharmacy benefit
PLIAGIS	You can have up to 30mg/month
PODOCON 25 IN BENZOIN TIN	Not covered under pharmacy benefit
polyethylene glycol 8000	Not covered under pharmacy benefit
pr benzoyl peroxide wash	Not covered under pharmacy benefit
PRADAXA	Step therapy has been removed
PRAVACHOL	You must first try 2 of atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin or rosuvastatin
PREVACID	You must first try 3 of esomeprazole mag, lansoprazole, omeprazole, pantoprazole or rabeprazole
PRILOSEC	You must first try 3 of esomeprazole mag, lansoprazole, omeprazole, pantoprazole or rabeprazole
PROCRIT	Non-preferred specialty drug; You must first try RETACRIT
PROSCAR	You must first try dutasteride or finasteride
PROTONIX	You must first try 3 of esomeprazole mag, lansoprazole, omeprazole, pantoprazole or rabeprazole
PROTOPIC	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PROVOCHOLINE	Not covered under pharmacy benefit

Prescription Drug Change	Change
PSORCON	You must first try augmented betamethasone; You can fill up to 60gm/ month
PULMICORT FLEXHALER	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
PYRIDIUM	Not covered under pharmacy benefit
QUDEXY XR	You must first try topiramate
RAGWITEK	Non-preferred brand drug; Preauthorization required*; You must first try 2 generic antihistamine drugs; You can fill up to 1/ day
RANEXA	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
READI-CAT 2	Not covered under pharmacy benefit
READI-CAT 2 BANANA SMOOTH	Not covered under pharmacy benefit
READI-CAT 2 BERRY SMOOTHI	Not covered under pharmacy benefit
READI-CAT 2 CREAMY VANILL	Not covered under pharmacy benefit
READI-CAT 2 MOCHACCINO SM	Not covered under pharmacy benefit
RECURA	Not covered under pharmacy benefit
RELAGARD GEL	Not covered under pharmacy benefit
RELPAX	You must first try 3 of naratriptan, rizatriptan, sumatriptan, or zolmitriptan
RESCRIPTOR	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
RIAX	Not covered under pharmacy benefit
salacyn	Not covered under pharmacy benefit
SALEX	Not covered under pharmacy benefit

Prescription Drug Change	Change
salicylic acid	Not covered under pharmacy benefit
salimez	Not covered under pharmacy benefit
salitech forte	Not covered under pharmacy benefit
seb-prev wash	Not covered under pharmacy benefit
SERNIVO	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try betamethasone; You can fill up to 120ml/ month
SEROQUEL XR	Preauthorization has been removed; You must first try 2 of risperidone, quetiapine, ziprasidone, aripirazole, or olanzapine
silver nitrate	Not covered under pharmacy benefit
sodium sulfacetamide	Not covered under pharmacy benefit
SODIUM SULFACETAMIDE WASH brand and generic	Not covered under pharmacy benefit
sodium sulfacetamide/sulf	Not covered under pharmacy benefit
SONATA	You must first try zolpidem, zaleplon or eszopiclone
STELARA INJ 45MG	You can fill up to 2 syringes/ 90 days
STELARA INJ 90MG	You can fill up to 2 syringes/ 60 days
sulfurated lime	Not covered under pharmacy benefit
SUPPRELIN LA	Not covered under pharmacy benefit; Preauthorization has been removed
SYMLINPEN 60	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
SYNALAR	You must first try triamcinolone
SYNERA	You can have up to 10 patches/month
TAGITOL V	Not covered under pharmacy benefit
TEMOVATE	You must first try augmented betamethasone

Prescription Drug Change	Change
TESTOPEL	Not covered under pharmacy benefit
tetcaine	Not covered under pharmacy benefit
tetracaine hcl	Not covered under pharmacy benefit
tetravisc	Not covered under pharmacy benefit
tetravisc forte	Not covered under pharmacy benefit
TOPICORT	You must first try betamethasone dipropionate
TOPROL XL	You must first try metoprolol succinate
TRAVATAN Z	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
TRIDESILON	You must first try alclometasone
triple dye	Not covered under pharmacy benefit
TROKENDI XR	You must first try topiramate
ULORIC	You must first try allopurinol
ULTRAVATE	You must first try augmented betamethasone
VANTAS	Not covered under pharmacy benefit; Preauthorization has been removed
VARIBAR HONEY	Not covered under pharmacy benefit
VARIBAR NECTAR	Not covered under pharmacy benefit
VARIBAR THIN HONEY	Not covered under pharmacy benefit
VARIBAR THIN LIQUID	Not covered under pharmacy benefit
VESICARE	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
VIIBRYD	You must first try 3 of fluoxetine, citalopram, duloxetine, venlafaxine, amitriptyline, nortriptyline, mirtazapine, trazodone

Prescription Drug Change	Change
VIRASAL	Not covered under pharmacy benefit
VITAMIN D CONTAINING PRODUCTS brand and generic	Not covered under pharmacy benefit
VOLUMEN	Not covered under pharmacy benefit
XALKORI	Must be filled through a specialty network pharmacy
XERMELO	Must be filled through a specialty network pharmacy
XIGDUO XR	Preferred brand drug
XTANDI	Must be filled through a specialty network pharmacy
XYLOCAINE	You can fill up to 50gm/ month
ZACLIR CLEANSING	Not covered under pharmacy benefit
ZEPATIER	Non-preferred specialty drug
ZOCOR	You must first try 2 of atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin or rosuvastatin
ZOLADEX	Not covered under pharmacy benefit; Preauthorization has been removed
ZOMIG	You must first try 3 of naratriptan, rizatriptan, sumatriptan, or zolmitriptan
ZYKADIA	Must be filled through a specialty network pharmacy

Please note that if your prescription drug benefits plan changes, the information in this letter may no longer apply.

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).

Some health benefits and health insurance plans are offered, administered and/or underwritten by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

Aetna receives rebates from drug manufacturers that may be taken into account in determining the Aetna Pharmacy Plan and Specialty Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Information is subject to change. For more information about your pharmacy plan, refer to your plan's website that is on your member ID card.

In accordance with state law, commercial fully insured (including HMO) members in Louisiana and Texas (except Federal Employee Health Benefit Plan members) who are receiving coverage for medications that are added or removed from the Aetna Pharmacy Plan and Specialty Drug List will continue to have those medications covered at the same benefit level until their plan's renewal date. In Texas, preauthorization approval is known as "preservice utilization review." It is not "verification" as defined by Texas law. Preauthorization means a determination that healthcare services proposed to be provided to a patient are medically necessary and appropriate.

In accordance with state law, fully insured commercial California HMO members (except Federal Employee Health Benefit Plan members) who are receiving coverage for medications that are to receive preauthorization or step-therapy reviews will continue to have those medications covered, for as long as the treating physician continues prescribing them, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition.

In accordance with state law, fully insured commercial Connecticut PPO members (except Federal Employee Health Benefit Plan members) who are receiving coverage for medications that are to receive preauthorization or step-therapy reviews will continue to have those medications covered for as long as the treating physician prescribes them, provided the drug is medically necessary and more medically beneficial than other covered drugs. Nothing in this section shall preclude the prescribing provider from prescribing another drug covered by the plan that is medically appropriate for the enrollee, nor shall anything in this section be construed to prohibit generic drug substitutions.

The drugs on the Aetna Pharmacy Plan and Specialty Drug List including formulary exclusions, preauthorization, quantity limit and step-therapy reviews are subject to change. The quantity limits and step-therapy drug coverage review programs are not available in all service areas. For example, step-therapy programs do not apply to fully insured members in Indiana. Step therapy does not apply to fully insured members in New Jersey. However, these programs are available to self-funded plans.

Aetna Pharmacy Management administers, but does not offer, insure or otherwise underwrite the prescription drug benefit portion of your health plan and has no financial responsibility therefor. Aetna Pharmacy Management refers to an internal business unit of Aetna Health Management, LLC.

This material is for information only. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. For more information you can refer to your plan's website.

TTY: 711

To access language services at no cost to you, call the number on your ID card.

Para acceder a los servicios de idiomas sin costo, llame al número que figura en su tarjeta de identificación. (Spanish)

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼 (Chinese)

Afin d'accéder aux services langagiers sans frais, veuillez composer le numéro inscrit sur votre carte d'identité. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tawagan ang numero sa inyong ID card. (Tagalog)

T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílı̨́go nanitinígíí bee néého’dólzinígíí béésh bee hane’í bikáá’ áajı̨’ hólne’. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an. (German)

Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقتك الشخصية. (Arabic)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք ձեր ինքնության (ID) քարտի վրա նշված հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z’indimi atakiguzi, Hamagara inumero iri kuri karangamuntu kawe. (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa numero sa nimong ID card. (Bisayan-Visayan)

သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပတ်အား ခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al número indicat a la seva targeta d’identificació. (Catalan)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion. (Chamorro)

ᏣᎩᏍᏗ ᏕᏬᏂᎯᏍᏗ ᎢᏳᎾᏝᏛᏁᏗ Ꮭ ᎪᎱᏍᏗ ᏗᏟᎬᏣᏔᏁᏗ ᏱᎩ, ᏫᏥᎯᏏᏔᏛᏏ ᎾᏍᎩ ᏗᏎᏍᏗ ᏥᏕᎪᏡᏢ ᎤᎾᎢ ID ᏆᏂᏲᏍᏗ ᏣᏙᏢᎢ. (Cherokee)

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla kvt chi holisso iskitini holhtena takanli ma I paya. (Choctaw)

Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa duugda waraaqaa eenyummaa (ID) kee irraa jiruun bilbili. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bel het nummer op uw ID-kaart. (Dutch)

Pou jwenn sèvis lang gratis, rele nimewo telefòn ki sou kat idantite ou a. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό που αναγράφεται στην κάρτα σας προνομίων μέλους. (Greek)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, તમારા આઇડી કાર્ડ ઉપરના નંબરને કોલ કરો. (Gujarati)

No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki ‘ole ‘ia kēia kōkua nei. (Hawaiian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिये नम्बर पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID. (Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ nọmba no na kaadị ID gị. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti numero idiay ID cardyo. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi nomor telepon di kartu identitas Anda. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero sulla tessera identificativa. (Italian)

言語サービスを無料でご利用いただくには、IDカードに記載の番号にお電話ください。(Japanese)

လၢတၢ်ကမၤန့ၢ်ကျိာ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်လၢတအိဉ်ဒီးအပှ့ၤလၢနကဘဉ်ဟ့ဉ်အီၤဘဉ်နှဉ်,ကိးဘဉ်လီတဲစိနီၢ်ဂံၢ်လၢအိဉ်လၢနတၢ်ဂီၤခိဉ် (ID) အခးလီၤန့ဉ်တက့ၢ် (Karen)

무료 언어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오. (Korean)

M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì pídyi ní, nìí, ɖá nɔ̀ɓà nìà nì ID káàɔ̀ kɔ̃ɛ. (Kru-Bassa)

بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی (ID)کارتی خۆت.
(Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ,
ໃຫ້ໂທຫາເບີໂທທີ່ບອກໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານ. (Laotian)

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, तुमच्या ID कार्डावरील क्रमांकावर फोन करा. (Marathi)

Nan etal nan jikin jiban ko ikijen kajin ilo an ejelok onen nan kwe, kirlok nomba eo ilo ID kaat eo am. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID. (Micronesian-Pohnpeian)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់
លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न आफ्नो परिचयपत्रमा भएको नम्बरमा टेलिफोन गर्नुहोस् । (Nepali)

Të kɔɔr yïn wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny në nɔmba de abac tɔ̈ në ID kard du kɔ̈u. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić numer telefonu na Twojej Karcie Identykującej (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para o número que consta na sua identidade. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul dvs. de identificare. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей карточке участника плана. (Russian)

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le numera I luga o lau pepa ID. (Samoan)

Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici. (Serbo-Croatian)

Heeba a nasta jangirde djey wolde, apelou lamba djey do windi ha dereji Maada. (Sudanic-Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga nambari iliyo kwenye kadi yako ya kitambulisho. (Swahili)

ܐܢ ܚܣܝܟܐ ܬܠܘܢ ܥܠ ܝܠܦܬܐ ܕܬܫܡܫܬܐ ܠܫܢܢܝܐ ܡܓܢܢܐܝܬ، ܩܪܘܢ ܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܦܘܪܫܢܘܬܐ ܕܝܘܟܢ. (Assyrian-Syriac)

మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, మీ ID కార్డుపై ఉన్న నంబరుకు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน (Thai)

Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he fika 'oku hā atu 'i ho'o ID kaati. (Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori ewe nampa mei mak won noum ena katen ID (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, kartınızdaki numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером, вказаним на Вашій ідентифікайній картці. (Ukrainian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، اپنے شناختی کارڈ پر درج نمبرپر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số điện thoại ghi trên thẻ ID (Nhận dạng) của quý vị. (Vietnamese)

צוטריט שפּראַך באַדינונגען אין קיין פּרייַז צו איר, רופן די נומער אויף דיין שייַן קאָרט. (Yiddish)

Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe nọmba ori káádi idánimọ rẹ. (Yoruba)

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).

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, Coventry Health Care plans and their affiliates (Aetna).