aetna®

April 1, 2019

Changes to your prescription drug coverage

There will be changes to the **Aetna Value Plan** drug list that start on **April 1, 2019**. It's 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. Your doctor can also request a medical exception if your drug has been removed from the formulary. If you have any questions, you can call us at the toll-free number on your member ID card.

The changes made to the prescription drugs in this chart are based on the plan you're currently a member of at the time this letter was sent.

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**
abacavir sulfate/lamivudine/zidovudine	You can fill up to 2/ day*
abacavir/lamivudine	You can fill up to 1/ day*
ADDERALL XR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
AIMOVIG INJ 140DOSE	You can fill up to 2 pens/28 days*
AIMOVIG INJ 70MG/ML	You can fill up to 1 pen/28 days*
AIRDUO RESPICLICK 113/14	You can fill up to 1 inhaler/ month*
AIRDUO RESPICLICK 232/14	You can fill up to 1 inhaler/ month*
AIRDUO RESPICLICK 55/14	You can fill up to 1 inhaler/ month*

Prescription Drug Change	Change
ALDARA	You can fill up to 1 packet/ day*
ALIVE PRENATAL MULTI-VITAMIN/PLANT DHA	Preferred generic drug; Some over-the-counter drugs may be covered with a prescription*
ANAPROX DS	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try naproxen sodium*
ANCOBON	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try flucytosine*
ARMONAIR RESPICLICK 113	You can fill up to 1 inhaler/ month*
ARMONAIR RESPICLICK 232	You can fill up to 1 inhaler/ month*
ARMONAIR RESPICLICK 55	You can fill up to 1 inhaler/ month*
ASMANEX TWISTHALER	You can fill up to 1 inhaler/ month*
ATABEX PRENATAL	Preferred generic drug; Some over-the-counter drugs may be covered with a prescription*
benzonatate	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try benzonatate 100mg, 200mg*
BIKTARVY	Preferred brand drug; Preauthorization has been removed; You can fill up to 1/ day*
CENTRUM SPECIALIST PRENATAL	Preferred generic drug; Some over-the-counter drugs may be covered with a prescription*
CITRANATAL BLOOM	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
CITRANATAL HARMONY	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
COMBIVIR	You can fill up to 2/ day*

Prescription Drug Change	Change
CRESTOR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
CVS PRENATAL GUMMY/DHA/FOLIC ACID	Preferred generic drug; Some over-the-counter drugs may be covered with a prescription*
DELSTRIGO	You must first try TRIUMEQ or TIVICAY plus TRUVADA or ISENTRESS plus TRUVADA or BIKTARVY*
DEXPAK 10 DAY	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try dexamethasone*
DEXPAK 13 DAY	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try dexamethasone*
DEXPAK 6 DAY	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try dexamethasone*
DICLEGIS	Preauthorization required*
DISALCID	Not covered under pharmacy benefit
DULERA	You can fill up to 2 inhalers/ month*
ENBRACE HR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
EPIDUO	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try adapalene-benzoyl peroxide*
EPZICOM	You can fill up to 1/ day*
EVEKEO	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
EVOTAZ	You can fill up to 1/ day*

Prescription Drug Change	Change
FEXMID	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try cyclobenzaprine*
FLOVENT HFA	You can fill up to 1 inhaler/ month*
fluticasone propionate/salmeterol	You can fill up to 1 inhaler/ month*
FOLET ONE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
FOLIKA-V	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
FURADANTIN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try nitrofurantoin*
GENVOYA	You must first try TRIUMEQ or TIVICAY plus TRUVADA or ISENTRESS plus TRUVADA or BIKTARVY*
imiquimod	You can fill up to 1 packet/ day*
imiquimod pump	You can fill up to 1 pump/ month*
INLYTA TAB 1MG	You can fill up to 6/ day*
JUXTAPID	You can fill up to 1/day*
KENALOG	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try triamcinolone*; You can fill up to 100 gm/30 days*
lamivudine/zidovudine	You can fill up to 2/ day*
LENVIMA 10 MG DAILY DOSE	You can fill up to 1/ day*
LENVIMA 14 MG DAILY DOSE	You can fill up to 2/ day*
LENVIMA 18 MG DAILY DOSE	You can fill up to 3/ day*
LENVIMA 20 MG DAILY DOSE	You can fill up to 2/ day*

Prescription Drug Change	Change
LENVIMA 24 MG DAILY DOSE	You can fill up to 3/ day*
LENVIMA 8 MG DAILY DOSE	You can fill up to 2/ day*
LEXAPRO	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try escitalopram*
LIALDA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try mesalamine*
LIDODERM	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
LIPITOR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
LOKELMA	You must first try sodium polystyrene sulfonate*
LYNPARZA CAP 50MG	You can fill up to 16/ day*
MAKENA	You must first try hydroxyprogesterone*
MEPHYTON	Non-preferred brand drug
metaxalone	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try cyclobenzaprine*
MIGERGOT	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try 3 of naratriptan, rizatriptan, sumatriptan, or zolmitriptan*
MOBIC	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try meloxicam*
NAMENDA XR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try memantine*

Prescription Drug Change	Change
NATACHEW	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
NATELLE ONE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
NEEVO DHA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
NESTABS ONE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
NEXA PLUS	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
NEXIUM	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
NILANDRON	Non-preferred brand drug
nitrofurantoin susp	Non-preferred generic drug
OB COMPLETE GOLD	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
OB COMPLETE ONE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
OB COMPLETE PETITE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
OB COMPLETE PREMIER	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay

Prescription Drug Change	Change
PIFELTRO	You can fill up to 1/ day*
POMALYST	You can fill up to 21/ month*
PREFERA OB	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PREFERAOB ONE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PREMESISRX	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PRENATAL + COMPLETE MULTI/DHA/CHOLINE/FOLATE	Preferred generic drug; Some over-the-counter drugs may be covered with a prescription*
PRENATAL + DHA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
prenatal adult gummy/dha/folic acid	Preferred generic drug; Some over-the-counter drugs may be covered with a prescription*
PRENATAL GUMMIES/DHA & FOLIC ACID	Preferred generic drug; Some over-the-counter drugs may be covered with a prescription*
PRENATE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PRENATE AM	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PRENATE DHA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PRENATE ELITE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay

Prescription Drug Change	Change
PRENATE ENHANCE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PRENATE ESSENTIAL	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PRENATE MINI	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PRENATE PIXIE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PRENATE RESTORE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PREZCOBIX	You can fill up to 1/ day*
PRIMACARE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PRISTIQ	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
RENVELA	Non-preferred brand drug
salsalate	Not covered under pharmacy benefit
SELECT-OB	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
SPRYCEL TAB 20MG	You can fill up to 3/ day*
SPRYCEL TAB 80MG	You can fill up to 1/ day*
STIVARGA	You can fill up to 84/ month*

Prescription Drug Change	Change
STRIBILD	You must first try TRIUMEQ or TIVICAY plus TRUVADA or ISENTRESS plus TRUVADA or BIKTARVY*
SYLATRON	You can fill up to 4 inj/ month*
SYMFI	You can fill up to 1/ day*
SYMFI LO	You can fill up to 1/ day*
SYMTUZA	You must first try TRIUMEQ or TIVICAY plus TRUVADA or ISENTRESS plus TRUVADA or BIKTARVY*; You can fill up to 1/ day*
TAMIFLU	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try oseltamivir*
TAPERDEX 6-DAY	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try dexamethasone*
TARCEVA TAB 25MG	You can fill up to 2/ day*
THERANATAL ONE	Preferred generic drug; Some over-the-counter drugs may be covered with a prescription*
triamcinolone aer spray	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try triamcinolone*; You can fill up to 100 gm/30 days*
TRISTART DHA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
TRISTART ONE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
TRIZIVIR	You can fill up to 2/ day*
TRUVADA	You can fill up to 1/ day*
TYKERB	You can fill up to 6/ day*

Prescription Drug Change	Change
VELTASSA	You must first try sodium polystyrene sulfonate*
VISCO-3	You must first try ORTHOVISC, MONOVISC, EUFLEXXA*
VITAFOL ULTRA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
VITAFOL-NANO	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
VITAFOL-OB	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
VITAFOL-ONE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
VITAMEDMD REDICHEW RX	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
VITAPEARL	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
VIVELLE-DOT	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try estradiol*
VOLTAREN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try diclofenac sodium*
WELCHOL	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try colesevelam*
ZYCLARA	You can fill up to 1 packet/ day*
ZYCLARA PUMP	You can fill up to 1 pump/ month*

Prescription Drug Change	Change
ZYKADIA	You can fill up to 3/ day*; Not covered at mail-order pharmacy
ZYLOPRIM	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try allopurinol*
ZYVOX	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay

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 ᏭᏬᏂᎯᏍᏗ ᎢᏅᎾᏓᏅᏁᏗ Ꮭ ᎪᏁᏍᏗ ᏗᏣᎬᏩᏁᏗ ᏱᎩ, ᏫᏚᎯᏏᏔᏅᏏ ᎾᏍᎩ ᏗᏎᏍᏗ ᏥᏚᎪᏄᎮ ᎤᎾᎢ ID ᏆᏂᏲᏍᏗ ᏣᏤᎵᎢ. (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)

လၢတၢ်ကမၤန့ၢ်ကျိာ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပှ့ၤလၢနကဘၣ်ဟ့ၣ်အီၤဘၣ်နှၣ်,ကိးဘၣ်လီတဲစိနီၣ်ဂံၢ်လၢအိၣ်လၢနတၢ်ဂ့ၤခိၣ် (ID) အခးလိၤန့ၣ်တက့ၢ် (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)

ܟܢ ܣܢܝܩܐ ܝܘܬܘܢ ܥܠ ܝܠܦܢܘܬܐ ܕܬܘܪܓܡܐ ܒܠܫܢܐ ܡܓܢܐܝܬ، ܩܪܘܢ ܠܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܡܫܘܕܥܢܘܬܐ ܕܝܠܘܟܘܢ. (Syriac-Assyrian)

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)

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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.

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