



January 1, 2019

Changes to your prescription drug coverage

There will be changes to the **Aetna Commercial Self-insured and Fully-insured non-standard 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 |
|--------------------------|--|
| altacaine | Not covered under pharmacy benefit |
| altafluor | Not covered under pharmacy benefit |
| APEXICON E | You must first try augmented betamethasone; You can fill up to 60gm/ month |
| 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 |
| AUSTEDO | Must be filled through a specialty network pharmacy |
| 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 |
| BENZEFOAM | Not covered under pharmacy benefit |
| BENZEFOAM ULTRA | Not covered under pharmacy benefit |

| Prescription Drug Change | Change |
|-----------------------------------|--|
| benzeopro | Not covered under pharmacy benefit |
| benzeopro creamy wash | Not covered under pharmacy benefit |
| benzeopro foaming cloths | Not covered under pharmacy benefit |
| benzeopro short contact | Not covered under pharmacy benefit |
| benzoyl peroxide | Not covered under pharmacy benefit |
| benzoyl peroxide short co | Not covered under pharmacy benefit |
| 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 |
| 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 |
| cocaine hcl sol 4% | Not covered under pharmacy benefit |
| COPAXONE INJ 40MG/ML | Non-preferred specialty drug; You must first try GLATOPA, glatiramer |
| DEBACTEROL | Not covered under pharmacy benefit |
| DENTAL PRODUCTS brand and generic | Not covered under pharmacy benefit |
| diflorasone diacetate | You can fill up to 60gm/ month |
| DMT SUIK KIT | Not covered under pharmacy benefit |
| 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 |

| Prescription Drug Change | Change |
|------------------------------|--|
| 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 |
| 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 |
| ethyl chloride aerosol spray | Not covered under pharmacy benefit |
| 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 | You can fill up to 16 caps/ day |
| FENORTHO | 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 |
| fluor-i-strips a.t. | Not covered under pharmacy benefit |
| fluorescein-benoxinate | Not covered under pharmacy benefit |

| Prescription Drug Change | Change |
|---------------------------|--|
| FORMA-RAY | Not covered under pharmacy benefit |
| formadon | Not covered under pharmacy benefit |
| formaldehyde | Not covered under pharmacy benefit |
| FOSAMAX PLUS D | 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 |
| 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 |
| INDOCIN SUPPOSITORY | You must first try 2 generic non steroidal anti-inflammatory drugs; You can fill up to 4 suppositories/ day |
| INDOCIN SUSPENSION | 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 |
| KALETRA SOL | Non-preferred brand drug |
| KERALYT | Not covered under pharmacy benefit |
| lactic acid | Not covered under pharmacy benefit |
| LATUDA | 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 |

| Prescription Drug Change | Change |
|---------------------------------|--|
| 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 hcl | You can fill up to 50gm/ month |
| LIQUID POLIBAR PLUS | Not covered under pharmacy benefit |
| lugols strong iodine | Not covered under pharmacy benefit |
| 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 |
| METOPIRONE | Not covered under pharmacy benefit |
| 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 |

| Prescription Drug Change | Change |
|------------------------------|---|
| 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/ADOLESCENCE | 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 |
| OVACE PLUS WASH | Not covered under pharmacy benefit |
| OVACE WASH | Not covered under pharmacy benefit |
| 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 |
| 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 |

| Prescription Drug Change | Change |
|---------------------------|--|
| PROCRIT | Non-preferred specialty drug; You must first try RETACRIT |
| PROVOCHOLINE | Not covered under pharmacy benefit |
| PSORCON | 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 |
| 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 |
| 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 |
| salicylic acid | Not covered under pharmacy benefit |

| Prescription Drug Change | Change |
|---|--|
| salimez | Not covered under pharmacy benefit |
| salitech forte | Not covered under pharmacy benefit |
| seb-prev wash | Not covered under pharmacy benefit |
| SERNIVO | You must first try betamethasone; You can fill up to 120ml/ month |
| 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 |
| 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 |
| TAGITOL V | Not covered under pharmacy benefit |
| 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 |
| 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 |
| triple dye | Not covered under pharmacy benefit |

| Prescription Drug Change | Change |
|---|--|
| 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 | Preauthorization has been removed |
| VIIBRYD STARTER PACK | Preauthorization has been removed |
| 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 |
| ZOLADEX | Not covered under pharmacy benefit; Preauthorization has been removed |
| 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 bááh ílínígóó naaltsoos bee atah níłjigo nanitinígíí bee néého'dółzinígíí béésh bee hane'í bikáá' áají' 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)

የድንገተኛ አገልግሎቶችን ያለከፍያ ለማግኘት፣ በመታወቂያዎች ላይ ያለውን ቁጥር ይደውሉ። (Amharic)

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

Անվճար լեզվական ծառայություններին 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 မပေးရဲဘဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပါတ်အား 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)

[illegible]

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

Tajaajjiiloota 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 કોઈ 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 kālēka 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. (lbo)

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)

လၢတၢ်ကမၤန့ၢ်ကျိၣ်အတၢ်မၤစၢၤအတၢ်ဖဲးတၢ်မၤစတၢ်လၢတအိၣ်ဒီးအပ္ပၤလၢနကဘၣ်ဟ့ၣ်အိၣ်ဘၣ်န့ၣ်.ကိးဘၣ်လိတဖီနီၣ်ဂံၢ်လၢအိၣ်လၢနတၢ်ဂီၤဆိ (ID)
အခးလိၣ်တက့ၢ် (Karen)

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

M dyi wudu-dù kà kò dò bě dyi móuń nì pídýi ní, níí, dǎ nòbà nià nì ID káàò kǝ. (Kru-Bassa)

بۆ دەسپێر اگەشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەيوەندی بکە بە ژمارەى سەر ئای دى (ID) کارتی خۆت.
(Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ,
ໃຫ້ໂທຫາເບີໂທທຶບອກໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານ. (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, kirllok 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 yīn wěēr de thokic ke cīn wēu kɔr keek tēnɔŋ yīn. Ke cɔl kɔc ye kɔc kuɔny nē nɔmba de abac tō
nē ID kard du kōu. (Nilotic-Dinka)

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

Um Schprooch Services zu griegie 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)

Lati wonú awon ise èdè l’ofe fun o, pe nomba ori káádi idánimo re. (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).

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