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CALIFORNIA INSTITUTE OF TECHNOLOGY

Aetna Medicare℠ Plan (PPO)

Medicare (V02) PPO

MAPD 1201

Benefits and Premiums are effective January 01, 2019 through December 31, 2019

PLAN DESIGN AND BENEFITS

PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network Providers	Out-of-Network Providers
Annual Deductible	$0	$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.		
Annual Maximum Out-of-Pocket Amount	**Network services:**	**Network and out-of-network services:**
	$3,400	$10,000 for in and out-of-network services combined
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.		
Primary Care Physician Selection	Optional	Not Applicable
There is no requirement for member pre-certification. Your provider will do this on your behalf.		
Referral Requirement	There is no requirement for member pre-certification. Your provider will do this on your behalf.	
PREVENTIVE CARE	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Annual Wellness Exams One exam every 12 months.	$0	30%
Routine Physical Exams	$0	30%
Medicare Covered Immunizations Pneumococcal, Flu, Hepatitis B	$0	$0
Routine GYN Care **(Cervical and Vaginal Cancer Screenings)**	$0	30%

One routine GYN visit and pap smear every 24 months.		
Routine Mammograms (Breast Cancer Screening)	$0	30%
One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.		
Routine Prostate Cancer Screening Exam	$0	30%
For covered males age 50 & over, every 12 months.		
Routine Colorectal Cancer Screening	$0	30%
For all members age 50 & over.		
Routine Bone Mass Measurement	$0	30%
Additional Medicare Preventive Services*	$0	30%
Medicare Diabetes Prevention Program (MDPP)	$0	30%
12 months of core session for program eligible members with an indication of pre-diabetes.		
Routine Eye Exams	$0	30%
One annual exam every 12 months.		
Routine Hearing Screening	$0	30%
One exam every 12 months.		
PHYSICIAN SERVICES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Primary Care Physician Visits	$15	30%
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.		
Physician Specialist Visits	$40	30%
DIAGNOSTIC PROCEDURES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Outpatient Diagnostic Laboratory	$35	30%
Outpatient Diagnostic X-ray	$35	30%
Outpatient Diagnostic Testing	$35	30%
Outpatient Complex Imaging	$200	30%

EMERGENCY MEDICAL CARE	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Urgently Needed Care; Worldwide	$50	$50
Emergency Care; Worldwide (waived if admitted)	$90	$90
Ambulance Services	$100	30%

Observation Care

Your cost share for Observation Care is based upon the services you receive.

HOSPITAL CARE	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Inpatient Hospital Care	$200 copay per day, day(s) 1-7	30% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery	$185	30%
Blood	All components of blood are covered beginning with the first pint.	

MENTAL HEALTH SERVICES	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Inpatient Mental Health Care	$200 copay per day, day(s) 1-7	30% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Health Care	$40	30%

ALCOHOL/DRUG ABUSE SERVICES	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Inpatient Substance Abuse (Detox and Rehab)	$200 copay per day, day(s) 1-7	30% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Substance Abuse (Detox and Rehab)	$40	30%

OTHER SERVICES	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers

Skilled Nursing Facility (SNF) Care	$0 copay per day, day(s) 1-20; $172 copay per day, day(s) 21-100	30%

Limited to 100 days per Medicare Benefit Period**.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Home Health Agency Care	$0	30%
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.	
Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)	$40	30%
Cardiac Rehabilitation Services	$40	30%
Pulmonary Rehabilitation Services	$30	30%
Radiation Therapy	$60	30%
Chiropractic Services Limited to Original Medicare - covered services for manipulation of the spine.	$20	30%
Durable Medical Equipment/ Prosthetic Devices	20%	30%
Podiatry Services Limited to Original Medicare covered benefits only.	$40	30%
Diabetic Supplies Includes supplies to monitor your blood glucose from LifeScan.	$0	30%
Diabetic Eye Exams	$0	30%
Outpatient Dialysis Treatments	20%	20%
Medicare Part B Prescription Drugs	20%	30%
Medicare Covered Dental Non-routine care covered by Medicare.	$40	30%
ADDITIONAL NON-MEDICARE COVERED SERVICES		
Hearing Aid Reimbursement	$500 once every 36 months	

Resources for Living Covered

For help locating resources for every day needs.

PHARMACY - PRESCRIPTION DRUG BENEFITS

Calendar-year deductible for prescription drugs $260

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

Pharmacy Network S2

Your Medicare Part D plan is associated with pharmacies in the above network. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com).

Formulary (Drug List) GRP B2

Your cost for generic drugs is usually lower than your cost for brand drugs. However, Aetna in some instances combines higher cost generic drugs on brand tiers.

Initial Coverage Limit (ICL) $3,820

The Initial Coverage Limit includes the plan deductible, if applicable. This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

3 Tier Plan	Retail cost-sharing up to a 30-day supply	Retail cost-sharing up to a 90-day supply	Preferred mail order cost-sharing up to a 90-day supply
Tier 1 - Generic Generic Drugs	20%	20%	20%

3 Tier Plan	Retail cost-sharing up to a 30-day supply	Retail cost-sharing up to a 90-day supply	Preferred mail order cost-sharing up to a 90-day supply
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	25%	25%	25%
Tier 3 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	45%	45%	45%

Coverage Gap†

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage limit. Here's your cost-sharing for covered Part D drugs between the Initial Coverage limit until you reach $5,100 in prescription drug expenses:

Once you reach $3,820 in drug costs, you pay 37% coinsurance for generic drugs and 25% for brand drugs while in the Coverage Gap phase. Once you reach $5,100 in out of pocket drug expenses, you qualify for the Catastrophic Coverage phase.

Catastrophic Coverage	Greater of 5% of the cost of the drug - or - $3.40 for a generic drug or a drug that is treated like a generic and $8.50 for all other drugs.

Catastrophic Coverage benefits start once $5,100 in true out-of-pocket costs is incurred.

Requirements:

Precertification	Applies

Step-Therapy	Applies
Non-Part D Drug Rider	
	• Agents when used for anorexia, weight loss, or weight gain • Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations • Agents when used for the treatment of sexual or erectile dysfunction (ED) • Agents when used for the symptomatic relief of cough and colds • Agents used to promote fertility • Agents used for cosmetic purposes or hair growth

* Additional Medicare preventive services include:

- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use
- Screening and behavioral counseling for alcohol misuse
- Adult depression screening
- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease
- Behavioral therapy for HIV screening
- Hepatitis C screening
- Lung cancer screening

**A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Not all PPO Plans are available in all areas

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30 day supply. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com). Quantity limits and restrictions may apply.

The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

Your coverage is provided through a contract with your former employer/union/trust. The plan benefits administrator will provide you with information about your plan premium (if applicable).

If you reside in a long-term care facility, your cost share is the same as at a retail pharmacy and you may receive up to a 31 day supply.

Members who get "extra help" don't need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." So, most specialty drugs are not available at the mail-order cost share.

You must continue to pay your Part B premium.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

For mail-order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 7-10 days. You can call 1-888-792-3862, (TTY users should call 711) 24 hours a day, seven days a week, if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign-up for automated mail-order delivery.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's preferred drug list. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Pharmacy participation is subject to change.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some in- network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

†When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 37% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (63%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 37% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2019, that amount is $5,100. Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Coinsurance is applied against the overall cost of the drug, before any discounts or benefits are applied.

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs". These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Your Plan Includes Supplemental Coverage (Non-Part D Drug Rider)

Your Plan Includes a Supplemental Benefit Prescription Drug Rider. Certain types of drugs or categories of drugs are not normally covered by Medicare prescription drug plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." This plan offers additional coverage for some prescription drugs not normally covered. The amount paid when filling a prescription for these drugs does not count towards qualifying for catastrophic coverage. For those receiving Extra Help from Medicare to pay for prescriptions, the Extra Help will not pay for these drugs.

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Non-Part D drugs covered under the Supplemental Benefit Prescription Drug Rider are:

- Agents when used for anorexia, weight loss, or weight gain
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Agents when used for the treatment of sexual or erectile dysfunction (ED)
- Agents when used for the symptomatic relief of cough and colds
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth

Below is a list of non-Part D drugs that are **not** covered under the Supplemental Benefit Prescription Drug Rider:

- Non-prescription drugs
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

Non-Part D drugs covered under the rider can be purchased at the appropriate plan copay. Copayments and other costs for these prescription drugs will not apply toward the deductible, initial coverage limit or true out-of-pocket threshold. Some drugs may require prior authorization before they are covered under the plan. The physician can call Aetna for prior authorization, toll free at **1-800-414-2386**.

You can call Member Services at the number on the back of your Aetna Medicare member ID card if you have questions.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

You can read the *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711). Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

You can also visit our website at www.aetnaretireeplans.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Not all health services are covered. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, call the phone number listed in this material.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Aetna Medicare Grievance Department, P.O. Box 14067, Lexington, KY 40512. You can also file a grievance by phone by calling the phone number listed in this material (TTY: 711). If you need help filing a grievance, call the phone number listed in this material. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also contact the Aetna Civil Rights Coordinator by phone at 1-855-348-1369, by email at MedicareCRCoordinator@aetna.com, or by writing to Aetna Medicare Grievance Department, ATTN: Civil Rights Coordinator, P.O. Box 14067, Lexington, KY 40512.

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).

TTY: 711

If you speak a language other than English, free language assistance services are available. Visit our website or call the phone number listed in this document. (English)

Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento. (Spanish)

如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。(Traditional Chinese)

Kung hindi Ingles ang wikang inyong sinasalita, may maaari kayong kuning mga libreng serbisyo ng tulong sa wika. Bisitahin ang aming website o tawagan ang numero ng telepono na nakalista sa dokumentong ito. (Tagalog)

Si vous parlez une autre langue que l'anglais, des services d'assistance linguistique gratuits vous sont proposés. Visitez notre site Internet ou appelez le numéro indiqué dans ce document. (French)

Nếu quý vị nói một ngôn ngữ khác với Tiếng Anh, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí. Xin vào trang mạng của chúng tôi hoặc gọi số điện thoại ghi trong tài liệu này. (Vietnamese)

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Wenn Sie eine andere Sprache als Englisch sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Besuchen Sie unsere Website oder rufen Sie die Telefonnummer in diesem Dokument an. (German)

영어가 아닌 언어를 쓰시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 저희 웹사이트를 방문하시거나 본 문서에 기재된 전화번호로 연락해 주십시오. (Korean)

Если вы не владеете английским и говорите на другом языке, вам могут предоставить бесплатную языковую помощь. Посетите наш веб-сайт или позвоните по номеру, указанному в данном документе. (Russian)

إذا كنت تتحدث لغة غير الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متاحة. تفضل بزيارة موقعنا على الويب أو اتصل برقم الهاتف المدرج في هذا المستند. (Arabic)

अगर आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो मुफ्त भाषा सहायता सेवाएं उपलब्ध हैं। हमारी वेबसाइट परजाएं या इस दस्तावेज़ में दिए गए फोन नंबर पर कॉल करें। (Hindi)

Nel caso Lei parlasse una lingua diversa dall'inglese, sono disponibili servizi di assistenza linguistica gratuiti. Visiti il nostro sito web oppure chiami il numero di telefono elencato in questo documento. (Italian)

Caso você seja falante de um idioma diferente do inglês, serviços gratuitos de assistência a idiomas estão disponíveis. Acesse nosso site ou ligue para o número de telefone presente neste documento. (Portuguese)

Si ou pale yon lòt lang ki pa Anglè, wap jwenn sèvis asistans pou lang gratis ki disponib. Vizite sitwèb nou an oswa rele nan nimewo telefòn ki make nan dokiman sa a. (Haitian Creole)

Jeżeli nie posługują się Państwo językiem angielskim, dostępne są bezpłatne usługi wsparcia językowego. Proszę odwiedzić naszą witrynę lub zadzwonić pod numer podany w niniejszym dokumencie. (Polish)

英語をお話しにならない方は、無料の言語支援サービスを受けることができます。弊社のウェブサイトにアクセスするか、または本書に記載の電話番号にお問い合わせください。(Japanese)

Nëse nuk flisni gjuhën angleze, shërbime ndihmëse gjuhësore pa pagesë janë në dispozicionin tuaj. Vizitoni faqen tonë në internet ose merrni në telefon numrin e telefonit në këtë dokument. (Albanian)

ከእንግሊዝኛ ሌላ ቋንቋ የሚናገሩ ከሆነ ነጻ የቋንቋ ድጋፍ አገልግሎቶችን ማግኘት ይቻላል። የእኛን ድረ-ገጽ ይጎብኙ ወይም በዚህ ሰነድ ላይ የተዘረዘረውን ስልክ ቁጥር በመጠቀም ይደውሉ። (Amharic)

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Եթե խոսում եք անգլերենից բացի մեկ այլ լեզվով, ապա Ձեզ համար հասանելի են լեզվական աջակցման անվճար ծառայություններ: Այցելեք մեր վեբ կայքը կամ զանգահարեք այս փաստաթղթում նշված հեռախոսահամարով: (Armenian)

যদি আপনি ইংরেজী ব্যতীত অন্য কোনো ভাষায় কথা বলেনতাহলে বিনামূল্যের দোভাষীর পরিষেবা উপলব্ধ আছে।আমাদের ওয়েবসাইট দেখুন এবং এই নথিতে তালিকাভুক্ত ফোন নম্বরে ফোন করুন। (Bengali)

បើលោកអ្នកនិយាយភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនដោយឥតគិតថ្លៃ។ សូមចូលមើលគេហទំព័ររបស់យើងខ្ញុំ

ឬហៅទៅកាន់លេខទូរស័ព្ទដែលមាននៅក្នុងឯកសារនេះ។ (Khmer)

Ako govorite neki jezik koji nije engleski, dostupne su besplatne jezičke usluge. Posetite našu internet stranicu ili nazovite broj telefona navedenog u ovom dokumentu. (Serbo-Croatian)

Na ye jam thuɔŋdɛ̈t tënë thoŋ ë Dïŋlïth, ke kuɔɔny luilooi ë thok ë path aa tɔ̈ thïn. Nem yöt tɛ̈n internet tɛ̈dë ke yï cɔl akuën cɔ̈tmec cï gat thin në athör du yic. (Dinka)

Als u een andere taal spreekt dan Engels, is er gratis taalondersteuning beschikbaar. Bezoek onze website of bel naar het telefoonnummer in dit document. (Dutch)

Εάν ομιλείτε άλλη γλώσσα εκτός της Αγγλικής, υπάρχουν δωρεάν υπηρεσίες στη γλώσσα σας. Επισκεφθείτε την ιστοσελίδα μας ή καλέστε τον αριθμό τηλεφώνου που αναγράφεται στο παρόν έγγραφο. (Greek)

જો તમે અંગ્રેજી સિવાયની ભાષા બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ ઉપલબ્ધ છે. અમારી વેબસાઇટની મુલાકાત લો અથવા દસ્તાવેજમાં સૂચીબદ્ધ કરવામાં આવેલ ફોન નંબર પર કૉલ કરો. (Gujarati)

Yog hais tias koj hais ib hom lus uas tsis yog lus Askiv, muaj cov kev pab cuam txhais lus dawb pub rau koj. Mus saib peb lub website los yog hu rau tus xov tooj sau teev tseg nyob rau hauv daim ntawv no. (Hmong)

ຖ້າທ່ານເວົ້າພາສານອກເໜືອຈາກອັງກິດ, ການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ສັງຄ່າແມ່ນມີໃຫ້ທ່ານ. ໄປທີ່ເວັບໄຊທ໌ຂອງພວກເຮົາ ຫຼືໂທຕາມເບີໂທລະສັບທີ່ລະບຸໃນເອກະສານນ.ີ (Lao)

Bilagáana bizaad doo bee yáníłti'da dóó saad náánáłaʼ bee yáníłti'go, ataʼ haneʼ t'áá jíík'e bee áká i'doolwołígíí hóló. Béésh nitsékeesí bee na'ídíkid bá haz'ánígi ąąʼádíílíił éí doodago béésh bee haneʼí bee nihich'į' hodíílnih díí naaltsoos bikáá'ijį'. (Navajo)

Wann du en Schprooch anners as Englisch schwetzscht, Schprooch Helfe mitaus Koscht iss meeglich. Bsuch unsere Website odder ruf die Nummer uff des Document uff. (Pennsylvania Dutch)

اگر به زبان دیگری بجز انگلیسی گفتگو می کنید، کمک زبانی رایگان فراهم می باشد. به وبسایت ما مراجعه نمایید و یا به شماره تلفن که در سند ذیل لست شده، تماس بگیرید. (Farsi)

ਜੇ ਤੁਸੀਂ ਅੰਗ੍ਰੇਜ਼ੀ ਤੋਂ ਇਲਾਵਾ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਬੰਧੀ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਸਾਡੀ ਵੈੱਬਸਾਈਟ 'ਤੇਜਾਓ ਜਾਂ ਿਇਸ ਦਸਤਾਵੇਜ਼ ਵਿਚ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

Dacă vorbiți o altă limbă decât engleza, aveți la dispoziție servicii gratuite de asistență lingvistică. Vizitați site-ul nostru sau sunați la numărul de telefon specificat în acest document. (Romanian)

ܐܢ ܐܢܬܘܢ ܒܣ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܚܪܢܐ ܠܐ ܠܫܢܐ ܐܢܓܠܝܙܝܐ، ܐܝܬ ܦܘܠܚܢܐ ܕܡܣܝܥܢܘܬܐ ܡܓܢܢܝܬܐ ܕܠܫܢܐ. ܣܥܘܪܘܢ ܠܡܘܩܥܐ ܐܠܟܬܪܘܢܝܐ، ܝܢ ܩܪܘܢ ܡܢܝܢܐ ܕܬܠܦܘܢ ܕܪܫܝܡ ܥܠ ܗܕܐ ܟܬܒܢܘܬܐ (Syriac)

หากคุณพูดภาษาอื่นนอกเหนือจากภาษาอังกฤษ สามารถขอรับบริการช่วยเหลือด้านภาษาได้ฟรี เข้าไปที่เว็บไซต์ของเรา หรือโทรติดต่อหมายเลขโทรศัพท์ที่แสดงไว้ในเอกสารนี้ (Thai)

Якщо ви не говорите англійською, до ваших послуг безкоштовна служба мовної підтримки. Відвідайте наш веб-сайт або зателефонуйте за номером телефону, що зазначений у цьому документі. (Ukrainian)

اگر آپ انگریزی کے علاوہ دوسری زبان بولتے ہیں تو، زبان سے متعلق مدد کی مفت خدمات دستیاب ہیں۔ ہماری ویب سائٹ ملاحظہ کریں یا اس دستاویز میں درج فون نمبر پر کال کریں۔ (Urdu)

אויב איר רעדט א שפראך אויסער ענגליש, זענען שפראך הילף סערוויסעס אוועילעבל. באזוכט אונזער וועבזייטל אדער רופט דעם טעלעפאן נומער וואס שטייט אויף דעם דאקומענט. (Yiddish)

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, go to www.aetna.com.

Please contact Customer Service toll-free at 1-888-267-2637 (TTY: 711) for additional information. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

*****This is the end of this plan benefit summary*****

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