The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [http://www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) or by calling 1-866-378-0178. For general definitions of common terms, such as *allowed amount*, *balance billing*, *coinsurance*, *copayment*, *deductible*, *provider*, or other underlined terms see the Glossary. You can view the Glossary at [https://www.healthcare.gov/sbc-glossary/](https://www.healthcare.gov/sbc-glossary/) or call 1-866-378-0178 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>For each Plan Year, In-Network Individual: $250. Out-of-Network: Individual: $1,000.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Prescription drugs and emergency care; plus in-network office visits and preventive care are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes, For each Plan Year, Individual: $125 Prescription Drug Deductible. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>In-Network: Individual: $1,500. Out-of-Network: Individual: $3,000.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover &amp; penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-866-378-0178 for a list of in-network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>Yes, benefits will be paid at the Out-of-Network level without a referral.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 copay/visit, deductible doesn't apply</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$25 copay/visit, deductible doesn't apply</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td><strong>Copay/prescription, deductible doesn't apply:</strong> $15 (retail), $45 (mail order)</td>
<td><strong>Copay/prescription, deductible doesn't apply:</strong> $15 (retail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td><strong>Copay/prescription, deductible doesn't apply:</strong> $40 (retail), $120 (mail order)</td>
<td><strong>Copay/prescription, deductible doesn't apply:</strong> $40 (retail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td><strong>Copay/prescription, deductible doesn't apply:</strong> $80 (retail), $240 (mail order)</td>
<td><strong>Copay/prescription, deductible doesn't apply:</strong> $80 (retail)</td>
<td>Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women’s contraceptives in-network.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td></td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [www.aetna.com/individuals-families/find-a-medication.html](http://www.aetna.com/individuals-families/find-a-medication.html)

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**15.06.900.1**
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>In-Network Provider (You will pay the least): $200 copay/visit, deductible doesn't apply</td>
<td>Out-of-Network Provider (You will pay the most): $200 copay/visit, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>In-Network Provider (You will pay the least): No charge</td>
<td>Out-of-Network Provider (You will pay the most): 0% coinsurance No Charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>In-Network Provider (You will pay the least): $25 copay/visit, deductible doesn't apply</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>In-Network Provider (You will pay the least): Office: $25 copay/visit, deductible doesn't apply; other outpatient services: No charge</td>
<td>Out-of-Network Provider (You will pay the most): Office &amp; other outpatient services: 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>In-Network Provider (You will pay the least): No Charge</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-------------------------------</td>
<td>------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$25 copay/visit, deductible doesn't apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$25 copay/visit, deductible doesn't apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>

| If your child needs dental or eye care     | Children's eye exam           | No Charge                          | 50% coinsurance, deductible doesn't apply | 1 routine eye exam/plan year up to age 19. |
|                                            | Children's glasses            | No Charge                          | 50% coinsurance, deductible doesn't apply | 1 pair of glasses or lenses/plan year. |
|                                            | Children's dental check-up    | No Charge                          | 0% coinsurance                           | 2 routine dental exam/plan year up to age 19. |

**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Cosmetic Surgery</td>
</tr>
<tr>
<td>• Dental Care (Adult) - except accidental injury.</td>
</tr>
<tr>
<td>• Infertility Treatment -Except for charges made by a physician to diagnose and surgically treat the underlying medical cause.</td>
</tr>
<tr>
<td>• Long Term Care</td>
</tr>
<tr>
<td>• Routine Foot Care</td>
</tr>
<tr>
<td>• Weight Loss Programs- except for required preventive services.</td>
</tr>
</tbody>
</table>
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids – limited to 1 hearing aid per ear, per policy year
- Non-emergency care when traveling outside the U.S
- Private Duty Nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Arizona Department of Insurance, Consumer Services, (800) 325-2548, http://www.id.state.az.us/.

- For more information on your rights to continue coverage, contact the plan at 1-866-378-0178.

- For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-866-378-0178.

- Arizona Department of Insurance, Consumer Services, (800) 325-2548, http://www.id.state.az.us/.

Does this plan provide Minimum Essential Coverage? Yes.
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijijo holne’ 1-866-378-0178.

----------------------------------To see examples of how this plan might cover costs for a sample medical situation, see the next section.----------------------------------
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $250
- Specialist copayment: $25
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost**: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,300</td>
</tr>
</tbody>
</table>

**What isn’t covered**

Limits or exclusions: $60

**The total Peg would pay is**: $1,660

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $250
- Specialist copayment: $25
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost**: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

Limits or exclusions: $20

**The total Joe would pay is**: $1,520

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $250
- Specialist copayment: $25
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost**: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

Limits or exclusions: $0

**The total Mia would pay is**: $300

The **plan** would be responsible for the other costs of these EXAMPLE covered services.
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-378-0178.

Smartphone or Tablet
To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination
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: 1-860-262-7705)
Email: 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).
Language Assistance:

For language assistance in your language call 1-866-378-0178 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-866-378-0178.
Amharic - እን-quote እማን እ እማርኛ እ እማርኛ 1-866-378-0178 ከን እርለው-
Arabic - للمساعدة في (اللغة العربية)، الوجاء الاتصال على الرقم المجاني 1-866-378-0178
Armenian - Տեղակայության (հայերենի) համար 1-866-378-0178 անվճար գնալու:
Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-378-0178 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-866-378-0178 ku busa
Bengali-Bangala - বাংলায় ভাষায় সহায়তা জন্য বিনামূল্য 1-866-378-0178-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-378-0178 nga walay bayad.
Burmese - အာမာရာစိုက် (နိုင်ငံရေး) အများအားဖြင့် 1-866-378-0178 သို့ မည်ကြိုးပြောင်းပါ
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-866-378-0178.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-866-378-0178 sin gåstu.
Cherokee - ᎨᎦᏬᏂᏍᏗ ᎨᏗᏂᏍᏗᏲ (ᏣᎳᎩ) 1-866-378-0178 ᎨᏣᎳᎩ ᎨᏣᎳᎩ ᎨᏣᎳᎩ ᎨᏣᎳᎩ.
Chinese - 欲取得繁體中文語言協助，請撥打，無需付費。1-866-378-0178
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-866-378-0178.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf laakkokofsa bibilaa 1-866-378-0178 irratti bilisaan bibilaa.
French - Pour une assistance linguistique en français appeler le 1-866-378-0178 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-378-0178 gratis.
Cambodian - ការសំខាន់បានប្រការូបារាជាតិនឹងការបង្កើតប្រការូបារាជាតិនឹងទំព័រទី១ 1-866-378-0178 គ្រប់គ្រងក្នុងរត់។

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-378-0178 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં સહાય માટે કોલ પણ 1-866-378-0178 પર કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-866-378-0178. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-866-378-0178 पर मुफ़्त कॉल करें।


Ibo - Maka enyemaka aṣuṣu na Igbo kpọ 1-866-378-0178 na akwughị ugwo o bua

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-378-0178 nga awan ti bayadanyo.

Italian - Per riceverci assistenza linguistica in italiano, può chiamare gratuitamente 1-866-378-0178.

Japanese - 日本語で援助をご希望の方は、1-866-378-0178 まで無料でお電話ください。

Karen - 1-866-378-0178 v>wtrd.f'D;wfv>mfbl.fv>mfphRb.

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-378-0178 번으로 전화해 주십시오.

Kru-Bassa - Bé mì ké gbó-kpá-kpá dyé pidíq de Basso-wúquün wée, dâ 1-866-378-0178

Kurdish - برای راهنمایی به زبان فارسی با شماره 078178 86-866 به خوراى پاموئدی بکان.

Laotian - ຫົງການຕ້ອງງາມຂອງພາສາລາວ, ນະຄອນຫຼວງການ 1-866-378-0178ໂດຍບໍ່ເສຍຄ່ວຍໂທ.

Marathi - तीलभाषा(मराठी)सहाय्यासाठी 1-866-378-0178 क्रमांकावरकोणत्याहीखचार्षियासाठीकॉलकरा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-378-0178 ilo ejjelok wônân.

Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-378-0178 ni sohte isais.

Pohnpeyan - T'áá shi shizaad k'ehjí bee shiká a'doowol ninízingo Diné k'ehjí koji' t'áá jík'e hólne' 1-866-378-0178

Mon-Khmer, Cambodian - បាស់ភាសាខ្មែរនិងភាសាឍើម្បីការជួសជុល 1-866-378-0178 សម្រាប់ការជួសជុលប្រចាំឆ្នាំ។

Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol ninízingo Diné k'ehjí koji' t'áá jík'e hólne' 1-866-378-0178

Nepali - (लेपाली) मा लिंगको भाषा सहायता पाउनका लागि 1-866-378-0178 मा फोन कर्नुहोस्।

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Nilotic-Dinka - Tên kuɔɔny ê thɔk ê Thuɔnjän cəl 1-866-378-0178 kecïn ayöc.
Norwegian - For språkassistanse på norsk, ring 1-866-378-0178 kostnadsfritt.
Panjabi - ਪੰਜਾਬੀ ਵਿੰਦੂ ਇੰਦੂ ਮਾਰਗਿਂਡ ਲੰਘੀ, 1-866-378-0178 'ਵੇ ਸਹੁਲਤ ਵਾਰ ਲੜੀ।
Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-378 0178
Portuguese - Para obter assistência linguística em português ligue para o 1-866-378-0178
Romanian - Pentru asistență lingvistică în româneste telefonați la numărul gratuit 1-866-378 0178
Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-378-0178.
Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-378-0178 e aunoa ma se totogi.
Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-378-0178.
Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-378-0178.
Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-866-378-0178 Njodi woo fawaaki on.
Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-378-0178 bila malipo.
Telugu - తాగాలో బాంధం మనం మన సాగు చసూప సందర్శించు బిజించండి 1-866-378-0178 తెలుగు విదేశి సంకేతం (అంగానీ)
Thai - สั่งความช่วยเหลือทางภาษาเป็น ภาษาไทย โทร 1-866-378-0178 หรือไม่ค่าใช้จ่าย
Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefonii 1-866-378-0178 'o 'ikai hā tōtōngi.
Trukese - Ren áinnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-378-0178 nge esapw kamé ngonuk.

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