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, contact HR Services at 814-865-1473. 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/ or call 814-865-1473 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall <strong>deductible</strong>?</td>
<td>$625 individual/$1,250 family – In-network&lt;br&gt;$1,250 individual/$2,500 family – Out-of-network&lt;br&gt;The deductible does not apply to preventive services. Coinsurance amounts do not apply toward the deductible.</td>
<td>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your <strong>deductible</strong>?</td>
<td>Yes. Preventive services, office visits, emergency room services, urgent care, outpatient mental health, outpatient substance abuse and rehabilitation services and FDA-authorized COVID-19 diagnostic tests.</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.</td>
</tr>
<tr>
<td>Are there other <strong>deductibles</strong> for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>What is the <strong>out-of-pocket limit</strong> for this <strong>plan</strong>?</td>
<td>$1,250 individual/$2,500 family – In-network out-of-pocket limit (excludes deductible) up to a total out-of-pocket of $7,150 individual / $14,300 family.&lt;br&gt;$2,500 individual/$5,000 family – Out-of-network</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the <strong>out-of-pocket limit</strong>?</td>
<td>Premiums, balance-billed charges, prescription drug expenses and health care this plan does not cover do not apply to your total out of pocket limit.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a <strong>network provider</strong>?</td>
<td>Yes. For a list of in-network providers, visit Aetna’s DocFind at <a href="http://ohr.psu.edu/benefits">http://ohr.psu.edu/benefits</a> or the public DocFind at <a href="http://www.aetna.com">www.aetna.com</a>. You can also call the Penn State Aetna Concierge Team at 1-855-878-4197.</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>Do you need a <strong>referral</strong> to see a <strong>specialist</strong>?</td>
<td>No.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage

**What this Plan Covers & What You Pay For Covered Services**

**The Pennsylvania State University: PPO Plan – Band 4 - $90,000 and over**

**Coverage Period:** 01/01/2021 – 12/31/2021

**Coverage for:** Individual & Family | **Plan Type:** PPO

---

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>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td><strong>Primary care visit to treat an injury or illness</strong></td>
<td><strong>Network Provider (You will pay the least)</strong> $20 copay/visit</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong> 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist visit</strong></td>
<td><strong>$30 copay/visit</strong></td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Preventive care/screening/immunization</strong></td>
<td><strong>No Charge for preventive services</strong></td>
<td>30% coinsurance for preventive services</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td><strong>Diagnostic test (x-ray, labs / blood work)</strong></td>
<td>10% coinsurance (X-Ray) 10% coinsurance (Labs/Blood work - Quest/LabCorp) 30% coinsurance (Labs/Blood work - Freestanding lab, facility or hospital)</td>
<td>30% coinsurance (X-Ray) 50% coinsurance (Labs/Blood work)</td>
</tr>
<tr>
<td></td>
<td><strong>Imaging (CT/PET scans, MRIs)</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

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**Questions:** Call HR Services at (814) 865-1473 or visit us at [http://ohr.psu.edu/benefits](http://ohr.psu.edu/benefits).
### Summary of Benefits and Coverage

**What this Plan Covers & What You Pay For Covered Services**

**The Pennsylvania State University: PPO Plan – Band 4 - $90,000 and over**

<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></td>
<td></td>
<td>Network Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>Retail covers up to a 31 day supply Mail (including University Health Services pharmacy) covers up to a 90 day supply Prescription coinsurance amounts paid are not included in the deductible. Prescription-only Maximum Out-of-Pocket of $2,000 individual/ $8,000 family. Dispense as written penalties apply when the member request no substitution. Medications on Preventive Drug List, pay only the applicable coinsurance. The preventive Drug listing can be found on Penn State Open enrollment website.</td>
</tr>
<tr>
<td>Tier 1- Typically Generic drugs</td>
<td>Retail- 50% coinsurance Mail - 20% coinsurance Preventive - 10% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier 2- Typically Preferred brand drugs</td>
<td>Retail- 50% coinsurance Mail - 20% coinsurance Preventive - 20% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier 3- Typically Non-preferred brand drugs</td>
<td>Retail- 70% coinsurance Mail- 70% coinsurance Preventive- 40% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Preferred- 50% coinsurance with a $50 maximum Non-Preferred- 70% coinsurance with a $100 maximum</td>
<td>Not covered</td>
<td>Specialty drugs must be purchased through CVS Caremark Specialty Pharmacy. Maximum allowed per prescription is 31 days. Prescription coinsurance amounts paid are not included in the deductible. Prescription-only Maximum Out-of-Pocket of $2,000 individual/ $8,000 family. Dispense as written penalties apply when the member request no substitution.</td>
</tr>
</tbody>
</table>

If you need drugs to treat your illness or condition

More information about prescription drug coverage is available at [www.caremark.com](http://www.caremark.com) or by calling 844-462-0203

Questions: Call HR Services at (814) 865-1473 or visit us at [http://ohr.psu.edu/benefits](http://ohr.psu.edu/benefits).
### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

**The Pennsylvania State University: PPO Plan – Band 4 - $90,000 and over**

**Coverage Period:** 01/01/2021 – 12/31/2021  
**Coverage for:** Individual & Family | **Plan Type:** PPO

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<th>Common Medical Event</th>
<th>Services You May Need</th>
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<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
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<tr>
<td></td>
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<td>$100 copay/visit</td>
<td>$100 copay/visit</td>
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<td></td>
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<td>10% coinsurance</td>
<td>10% coinsurance</td>
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<td>$30 copay/visit</td>
<td>30% coinsurance</td>
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<td></td>
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<td>10% coinsurance</td>
<td>10% coinsurance</td>
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</table>
|                      |                       | 10% coinsurance | 30% coinsurance | May require pre-approval by the plan.  
May require pre-approval by the plan.  
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## Summary of Benefits and Coverage:

### What this Plan Covers & What You Pay For Covered Services

**The Pennsylvania State University: PPO Plan – Band 4 - $90,000 and over**

### Coverage Period: 01/01/2021 – 12/31/2021

**Coverage for:** Individual & Family | **Plan Type:** PPO

<table>
<thead>
<tr>
<th>If you need help recovering or have other special health needs</th>
<th>Rehabilitation services</th>
<th>$30 copay/visit</th>
<th>30% coinsurance</th>
<th>May require pre-approval by the plan. 24 visit maximum for speech therapy visits in a calendar year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>--- none ---</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require pre-approval by the plan. Combined in-network and out-of-network: 100 days per calendar year.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require pre-approval by the plan. Combined network and out-of-network: $300 maximum for wigs (cancer diagnosis only) per lifetime.</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require pre-approval by the plan.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If your child needs dental or eye care</th>
<th>Children’s eye exam</th>
<th>Not covered</th>
<th>Not covered</th>
<th>--- none ---</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>--- none ---</td>
<td></td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>--- none ---</td>
<td></td>
</tr>
</tbody>
</table>

### 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:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.
- Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://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 on how 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.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [http://www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: [http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html](http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html).

### Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan Meet Minimum Value Standard? **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.

---

*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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
<td>$600</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$30</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>10%</td>
<td>Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>10%</td>
<td>Other coinsurance</td>
</tr>
</tbody>
</table>

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)

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)

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

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Peg would pay:</td>
<td>Cost Sharing</td>
</tr>
<tr>
<td>Deductibles</td>
<td>$600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$30</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$800</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$1,490</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$5,600</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Joe would pay:</td>
<td>Cost Sharing</td>
</tr>
<tr>
<td>Deductibles</td>
<td>$600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,800</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$20</td>
</tr>
<tr>
<td>The total Joe would pay is</td>
<td>$2,620</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$2,800</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Mia would pay:</td>
<td>Cost Sharing</td>
</tr>
<tr>
<td>Deductibles</td>
<td>$600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$70</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td>$970</td>
</tr>
</tbody>
</table>

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 1-800-370-4525.

**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 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, contact our Civil Rights Coordinator.

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: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. 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, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).


Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.
TTY: 711
Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Per asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.

Amharic - ኢልክን ኤክት ነ ከማርና ይ ከ 1-800-370-4526 የሚ እርከው ህካር

Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526

Armenian - Անվանքն գնագործական առատորակություն (հարցվեք) գնացք 1-800-370-4526 անվանք գնացք:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera urugufasha mu Kirundi, twakwwe kun yi nomeko 1-800-370-4526 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনিময়ে 1-800-370-4526-এ কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.

Burmese - ဖျင်ဆိုင်မှု ဖြစ်ပါစေ (မြန်မာ) သို့ 1-800-370-4526 ဖြင့် မူစေမည်

Catalan - Per rebre assistència en (català), truquí al número gratuït 1-800-370-4526.

Chamorro - Para ayuda gi fino’ (Chamoru), ågang 1-800-370-4526 sin gástu.

Cherokee - ᓀᐦeenth ᏲᏂᏣᎫᏥ ᓁᏨᎦᐟᏬᏣᏪ ᎠᏂᏣᏥᏯ ᎰᏨᏥᏬ (GWI) ᎢᏦᏣᏫ�� 1-800-370-4526 ᎨᏦ_containere deEG.PA hIR.θ.

Chinese - 欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。

Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-370-4526.

Cushite - Gargaarsa afana Oromiffa hükküu argachuuuf lakkokkofsaa bilbilaa 1-800-370-4526 irratti bilissan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.

French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyol Ayisyen, rele nimewo 1-800-370-4526 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં માનવની સહાય મળી શકે કોઈ પણ ભાષા પગાર 1-800-370-4526 પર કોઈ કરો.
No ke kōkua ma ka ʻōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ʻole ia kēia kōkua nei.

Hindi -
हिंदी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।

Hmong -
Yog xav tau kev pab txhais hau Hmoo vub hau davb tau rau 1-800-370-4526.

Ibo -
Maka enyemaka asụsụ na Igbo keto 1-800-370-4526 na akwụkwọ ụgwọ ọ bua.

Ilocano -
Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.

Italian -
Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.

Japanese -
日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。

Karen -
က်နိုးတို့ကို ကောင်းစီနိုင်သော အတိုက် 1-800-370-4526 ကျပ်ကျပ် ရန်ကုန်ခြင်း ကျပ်ကျပ် ရန်ကုန်ခြင်း

Korean -
한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526번으로 전화해 주십시오.

Kru-Bassa -
Bɛ’m’ê gbo-kpá-kpá dyé pidyi dë Basoř-wuqwu’in weë, dâ 1-800-370-4526

Kurdish -
برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خوزستان پیوسته بکنید.

Laotian -
Rhâk tam saam tlaam tlaam siam tlaam tlaam siam tlaam 1-800-370-4526 dai yey pha lai ti.

Marathi -
तीलमासा (मराठी) सहाय्यासाठी 1-800-370-4526 कर्मांकासारख्यांसाठीहस्तांशविभागाच्याकोल्कता.

Marshallese -
Nan bok jipa ilo Kajin Majol, kallok 1-800-370-4526 ilo eijcok wônân.

Micronesian-Pohnpeian -
Ohng palien sawas en souw kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.

Mon-Khmer -
ប្រើប្រាស់ជាមួយក្រុមហ៊ុនការវិភាគីស្ថានីយ៍ 1-800-370-4526 ដើម្បីការការពិភាក្សារបស់ខ្លួនឯង។

Navajo -
T'áá shíida k'ehéjí bee shiká ad'ooowol n'ños'go Diné k'ehéjí ko'ii t'áá jí'k'e hólne' 1-800-370-4526

Nepali -
(नेपाली) मा निर्देशक भाषा सहायता पाउनका लागाउँ 1-800-370-4526 मा फोन गर्नुहोस्।

Nilotic-Dinka -
Tén kuony é thok é Thuonján col 1-800-370-4526 kecín ayoc.

Norwegian -
For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.

Panjabi -
ਪੰਜਾਬੀ ਦੀ ਉਪਾਧਿ ਮਾਦਰੀਡ ਸਰਥੀ, 1-800-370-4526 ਉੱਤੇ ਭਾਸ਼ਾ ਬਣੁਤਾ ਵੇਅੜੀ।

Pennsylvania Dutch -
Per Helfe in Deitsch, ruf 1-800-370-4526 aa. Es Aaruf koschtet nix.

Persian -
برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هزینه ای تماس بگیرید. انگلیسی

Polish -
Aby uzyskać pomoc w języku polskim, zadzwonić bezpłatnie pod numer 1-800-370-4526.