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# Aetna Student Health

# Dental Plan Design and Benefits Summary

### Preferred Provider Organization (PPO)

## Rocky Vista University

Policy Year: 2024 - 2025
Policy Number: 479677
www.aetnastudenthealth.com
(877) 238-6200

**This Aetna Dental® Preferred Provider Organization (PPO) insurance plan summary is provided by Aetna Life Insurance Company (Aetna)** for some of the more frequently performed dental procedures. Under this plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the PPO participating dentists have agreed to provide care for covered services at the negotiated fee schedule.

## Coverage Periods

**Students:** Coverage for eligible students will become effective at or after 12:00 a.m. on the coverage dates indicated on the Master Policy and will terminate at or before 11:59 p.m. on the coverage dates on the Master Policy.

**Eligible Dependents**: Dependents are not eligible for Rocky Vista University's Aetna PPO Dental Plan.

## Rates

| 2024-2025 Student Dental Plan Rate | |
|---|---|
| Annual* | $280.00 |
| Fall* | $140.00 |
| Spring* | $140.00 |

* The premium listed above is included in the RVU Annual Student Health Insurance Premium.

## Who is eligible?

You are eligible if you are a:

- Student enrolled in the Rocky Vista University Student Health Insurance Plan.
    - All students are automatically enrolled in the Aetna PPO Dental Plan.

## Dependent Coverage

Dependents are not eligible for Rocky Vista University's Aetna PPO Dental Plan.

## Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are eligible dental services, the foundation for getting covered care is through our network.

This section tells you about in-network and out-of-network providers.

### In-network providers

We have contracted with dental providers to provide eligible dental services to you. These dental providers make up the network for your plan.

You may select an in-network provider from the directory or by logging on to our website at www.aetnastudenthealth.com. You can search our online directory, DocFind®, for names and locations of dental providers.

You will not have to submit claims for treatment received from in-network providers. Your in-network provider will take care of that for you. And we will directly pay the in-network provider for what the plan owes.

### Out-of-network providers

If you use an out-of-network provider to receive eligible dental services, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying any out-of-network deductibles
- Your out-of-network coinsurance
- Any charges above the scheduled limit
- Any charges over our recognized charge
- Submitting your own claims

## Description of Benefits

The Plan excludes coverage for certain services (referred to as exceptions and exclusions in the certificate of coverage) and has limitations on the amounts it will pay. While this Plan Design and Benefit Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Certificate of Coverage issued to you, go to **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

This Plan will pay benefits in accordance with any applicable Colorado Insurance Law(s).

### Policy year Deductibles

You have to meet your policy year deductible before this plan pays for benefits.

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Policy year deductible** | Individual: $50 | |
| The policy year deductible applies to all eligible dental services except Type A expenses. | | |

### Coinsurance listed in the schedule of benefits

The **coinsurance** listed in the schedule of benefits below reflects the plan **coinsurance** percentage. This is the **coinsurance** amount that the plan pays. You are responsible for paying any remaining **coinsurance**.

### Coinsurance

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Type A expenses** | 100% of the **negotiated charge** | 100% of the **recognized charge** |
| **Type B expenses** | 80% of the **negotiated charge** | 60% of the **recognized charge** |
| **Type C expenses** | 50% of the **negotiated charge** | 50% of the **recognized charge** |
| **Orthodontic treatment expenses** | Not Covered | Not Covered |

### Policy year maximum

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Policy year maximum:** | Individual: $1,000 | |
| The policy year maximum applies to:<br>• in-network and out-of-network eligible dental services combined | | |

# Eligible dental services

## Type A expenses: Diagnostic & preventive care

### Visits and exams

- Office visit during regular office hours for oral examination (2 visits per policy year)
- Prophylaxis (cleaning) or scaling-moderate/severe inflammation–full mouth (2 treatments per policy year)
- Topical application of fluoride if you are under age 16 (1 applications per policy year)
- HbA1c in-office point of service testing (1 test per policy year)

### Images and pathology

- Bitewing images (1 set per policy year)
- Entire dental series, including bitewings or panoramic film (1 set every 5 policy years)
- Vertical bitewing images (1 set every 5 policy years)

## Type B expenses: Basic restorative care

### Visits and exams

- Office visit after hours (we will pay either for the office visit charge or for the **eligible** dental services performed, whichever is more)
- Emergency palliative treatment, per visit
- Sealants, per tooth (1 application every 3 policy years for permanent molars only and if you are under age 16)
- Sealant repair - per tooth (for permanent molars only and if you are under age 16)

### Images and pathology

- Periapical images
- Intra-oral, occlusal view
- Extra-oral
- Accession of tissue

### Restorative

Excluding inlays, onlays and crowns. Multiple restorations in 1 surface will be considered as a single restoration.

- Amalgam restorations
- Resin-based composite restorations, (other than for molars)
- Protective restoration
- Reattachment of tooth fragment, incisal edge or cusp
- Interim therapeutic restoration – primary dentition
- Pin retention, per tooth, in addition to restoration

## Type C expenses: Major restorative care

**Restorative** – Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only as treatment for decay or acute traumatic injury, and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. Coverage is limited to 1 per tooth every 8 policy years. (See the *Replacement rule*.)

- Inlays
- Onlays
- Labial veneers
- Crowns
- Prefabricated crowns (excluding temporary crowns)

- Post and core
- Recementation
- Repairs - inlay, onlay, veneer, crow

**Endodontics**

- Pulp cap
- Pulpal debridement
- Pulpal therapy
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy and retreatment
  - Anterior
  - Bicuspid
  - Molar
- Pulpal regeneration
- Periradicular surgery without apicoectomy
- Hemisection
- Retrograde filling
- Root amputation
- Treatment of root canal obstruction
- Incomplete endodontic surgery
- Internal root repair of defect

**Periodontics**

- Periodontal maintenance (following active therapy (1 per policy year)
- Occlusal adjustment, (other than with an appliance or by restoration)
- Osseous surgery, (including flap and closure), 1 to 3 teeth per quadrant (1 per site every 3 policy years)
- Osseous surgery, (including flap and closure), 4 or more per teeth per quadrant (1 per quadrant every 3 policy years)
- Soft tissue graft procedures
- Clinical crown lengthening - hard tissue
- Full mouth debridement (1 per lifetime maximum)
- Bone grafts, first site in quadrant (1 per lifetime maximum)
- Bone grafts, each additional site in quadrant (1 per lifetime maximum)
- Root planing and scaling, 1 to 3 teeth per quadrant (4 per site, every 2 policy years)
- Root planing and scaling, 4 or more teeth per quadrant, (4 per site, every 2 policy years)
- Scaling and debridement – implant (1 tooth every 2 policy years)
- Surgical revision procedure, per tooth
- Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant (1 per site every 3 policy years)
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant (1 per site every 3 policy years)
- Gingival flap procedure, 1 to 3 teeth per quadrant (1 per site every 3 policy years)
- Gingival flap procedure, 4 or more teeth per quadrant (1 per site every 3 policy years)
- Apically positioned flap
- Unscheduled dressing change (by someone other than treating dentist or their staff)

**Prosthodontics**

The first installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 10 policy years old. (See the *Tooth missing but not replaced rule*.) Replacement of existing bridges or dentures is limited to 1 every 8 policy years. (See the *Replacement rule*.)

- Bridge abutments
- Pontics
- Implants
- Dentures and partials (fees for dentures and partial dentures include relines, rebases and adjustments within 6-36 months after installation. Fees for relines and rebases include adjustments within 6-36 months after installation. Specialized techniques and characterizations are not eligible).
  - Complete upper and lower denture
  - Partial upper and lower (including any conventional clasps, rests and teeth)
  - Removable unilateral partial denture
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Reline (partial or complete)
- Rebase, per denture
- Special tissue conditioning, per denture
- Adjustment to denture more than 6 months after installation
- Repairs, full and partial denture
- Adding teeth and clasps to existing partial denture
- Repairs, bridges
- Occlusal guard for bruxism (1 every 5 policy years)
- Adjustments, repair or reline of occlusal guard
- Cleaning and inspection of a removable appliance

**Oral surgery**

- Extractions – coronal remnants – deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of erupted tooth
- Removal of impacted tooth
  - Soft tissue
  - Partially bony
  - Completely bony
- Surgical removal of residual tooth roots
- Coronectomy
- Primary closure of a sinus perforation
- Oroantral fistula closure
- Tooth transplantation
- Surgical access of unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Biospy of oral tissue
- Exfoliative cytological sample collection
- Alveoloplasty
- Removal of odontogenic cysts or tumors
- Removal of exostosis

- Removal of torus
- Surgical reduction of osseous tuberosity
- Incision and drainage of abscess
- Removal of foreign body
- Sequestrectomy
- Suture of wounds
- Frenectomy/frenuloplasty
- Excision of hyperplastic tissue per arch
- Excision of pericoronal gingiva
- Surgical reduction of fibrous tuberosity
- Sialolithotomy
- Closure of salivary fistula
- Treatment of complications (post-surgical)

**General anesthesia and intravenous sedation**

- General anesthesia and intravenous sedation are covered when provided as part of a covered surgical procedure
- Evaluation by anesthesiologist for deep sedation or general anesthesia

**Nutritional counseling**

Limited to nutritional counseling for the control of dental disease

**Tobacco counseling**

Limited to tobacco counseling for the control and prevention of oral disease

**Space maintainers**

Only when needed to preserve 9space resulting from premature loss of deciduous teeth and if you are under age 14. 1 course of treatment per **policy year**. (Includes all adjustments within 6 months after installation.)

- Fixed or removable (unilateral or bilateral)
- Recementation or removal
- Appliance therapy to control harmful habits

## Dental emergency

**Eligible dental services** include dental services provided for a **dental emergency**. The care provided must be a **covered benefit**.

If you have a **dental emergency**, you should consider calling your dental **in-network provider** who may be more familiar with your dental needs. However, you can get treatment from any **dentist** including one that is an **out-of-network provider**. If you need help in finding a **dentist**, call Member Services at the toll-free number on the back of your ID card.

If you get treatment from an **out-of-network provider** for a **dental emergency**, the plan pays a benefit at the in-network cost-sharing level of coverage.

For follow-up care to treat the **dental emergency**, you should consider using your **in-network dental provider** so that you can get the maximum level of benefits. Follow-up care will be paid at the cost-sharing level that applies to the type of **provider** that gives you the care.

## Limitations/exclusions (what is not covered)

We already told you about the many dental care services and supplies that are eligible for coverage under your plan in the *Benefits/coverage (what is covered)* section. In that section we also told you that some dental care services and supplies have exceptions and some are not covered at all which are called "exclusions".

## Limitations/exclusions

**Beyond legal authority**

- Services and supplies provided by a **health professional** or other **provider** that is acting beyond the scope of its legal authority

**Charges for services or supplies**

- Provided by an **in-network provider** in excess of the **negotiated charge**
- Provided by an **out-of-network provider** in excess of the **recognized charge**
- Provided for your personal comfort or convenience, or the convenience of any other person, including a **dental provider**
- Provided in connection with treatment or care that is not covered under the plan
- Cancelled or missed appointment charges or charges to complete claim forms
- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage, including:
  - Care in charitable institutions
  - Care for conditions related to current or previous military service
  - Care while in the custody of a governmental authority

**Charges in excess of any benefit limits**

Any charges in excess of the benefit, dollar, visit, or frequency limits stated in the schedule of benefits.

**Cosmetic services and plastic surgery** (except to the extent coverage is specifically provided in the *Eligible Dental Services* section of the schedule of benefits)

- **Cosmetic** services and supplies including:
  - Plastic surgery
  - Reconstructive surgery
  - **Cosmetic** surgery
  - Personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty and other services to protect, clean, whiten, bleach alter the appearance of teeth whether or not for psychological or emotional reasons

Facings on molar crowns and pontics will always be considered **cosmetic**

**Court-ordered services and supplies**

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding.

**Dental services and supplies**

- Acupuncture, acupressure and acupuncture therapy
- Asynchronous dental treatment
- Crown, inlays and onlays, and veneers unless for one of the following:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the *Eligible Dental Services* section of the schedule of benefits
- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth, all of which were lost while you were not covered
- General anesthesia and intravenous sedation, unless specifically covered and done in connection with another **eligible dental service**
- Instruction for diet, tobacco counseling and oral hygiene
- Mail order and at-home kits for orthodontic treatment
- **Orthodontic treatment** except as covered in the *Eligible Dental Services* section of the schedule of benefits
- Services and supplies provided in connection with treatment or care that is not covered under the plan
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons
- **Temporomandibular joint dysfunction/disorder**

**Dental services and supplies that are covered in whole or in part:**

- Under any other part of this plan
- Under any other plan of group benefits provided by the **policyholder**

**Examinations**

Any dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.

- Because a court order requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

**Experimental or investigational**

- **Experimental or investigational** drugs, devices, treatments or procedures

**Felony**

- Services and supplies that you receive as a result of an **injury** due to your commission of a felony

**Judgment or settlement**

- Services and supplies for the treatment of an **injury** or **illness** to the extent that payment is made as a judgment or settlement by any person deemed responsible for the **injury** or **illness** (or their insurers)

**Mandatory no-fault laws**

- Treatment for an **injury** to the extent benefits are payable under any state no-fault automobile coverage or first party medical benefits payable under any other mandatory no-fault law

**Motor vehicle accidents**

- Services and supplies given by a **provider** for **injuries** sustained from a motor vehicle **accident** but only when benefits are payable under other valid and collectible insurance. This applies whether or not a claim is made for such benefits.

**Non-medically necessary services**

- Services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary** (as determined by **Aetna**) for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

**Non-U.S .citizen**

- Services and supplies received by a **covered person** (who is not a United States citizen) within the **covered person's** home country but only if the home country has a socialized medicine program

**Other primary payer**

- Payment for a portion of the charge that another party is responsible for as the primary payer

**Outpatient prescription drugs, and preventive care drugs and supplements**

- Prescribed drugs, pre-medication or analgesia

**Personal care, comfort or convenience items**

- Any service or supply primarily for your convenience and personal comfort or that of a third party

**Providers and other health professionals**

- Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentist**. These are:
  - Scaling of teeth
  - Cleaning of teeth
  - Topical application of fluoride
- Charges submitted for services by an unlicensed **provider** or not within the scope of the **provider's** license

**Riot**

- Services and supplies that you receive from **providers** as a result of an **injury** from your "participation in a riot". This means when you take part in a riot in any way such as inciting, or conspiring to incite, the riot. It does not include actions that you take in self-defense as long as they are not against people who are trying to restore law and order.

**Services paid under your medical plan**

- Your plan will not pay for amounts that were paid for the same services under a medical plan covering you. When a dental service is covered under both plans, we will figure the amount that would be payable under this plan if you did not have other coverage, then subtract what was paid by your medical plan. If there is any difference, this plan will pay it. If the amount paid by your medical plan is equal to or more than the benefit under this plan, this plan will not pay anything for the service.

**Services provided by a family member**

- Services provided by a spouse, civil union partner, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

**Services, supplies and prescription drugs received outside of the United States**

- Services, supplies, and **prescription drugs** received outside of the United States. They are not covered even if they are covered in the United States under this certificate of coverage.

**Sports**

- Any services or supplies given by **providers** as a result from play or practice of collegiate or intercollegiate sports, not including intercollegiate club sports and intramurals

**Temporomandibular joint dysfunction/disorder**

- The following services and supplies:
  - **Orthodontic treatment**
  - Crowns, bridges and dentures
  - Treatment of periodontal disease
  - Implants
  - Root canal therapy

**Treatment in a federal, state, or governmental entity**

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

**Valid and collectable insurance**

- Services and supplies covered by any other valid and collectible medical, dental, health, or **accident** insurance but only to the extent that benefits are payable under other valid and collectible insurance. This applies whether or not a claim is made for such benefits.

**Work related illness or injuries**

- Coverage available to you under workers' compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered "not work related" regardless of cause.

## What rules and limits apply to dental care?

Several rules apply to the dental benefits. Following these rules will help you use your plan to your advantage by avoiding expenses that are not covered by your plan.

### Alternate treatment rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

If a charge is made for a non-eligible dental service or supply and an **eligible dental service** that would provide an acceptable result, then your plan will pay a benefit for the **eligible dental service** or supply.

If a charge is made for an **eligible dental service** but another **eligible dental service** that would provide an acceptable result is less expensive, the benefit will be for the least expensive **eligible dental service**.

The benefit will be based on the **in-network provider**'s **negotiated charge** for the **eligible dental service** or, in the case of an **out-of-network provider**, on the **recognized charge**.

You should review the differences in the cost of alternate treatment with your **dental provider**. Of course, you and your **dental provider** can still choose the more costly treatment method. You are responsible for any charges in excess of what your plan will cover.

## Cleft lip and palate treatment rule

**Eligible dental services** are provided for cleft lip and palate to the same extent as other dental conditions. Any waiting periods will apply.

## Coverage for dental work begun before you are covered by the plan

Your plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan

## Reimbursement policies

We have the right to apply **Aetna** reimbursement policies. Those policies may reduce the **negotiated charge** or **recognized charge.** These policies take into account factors such as:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the **provider**

**Aetna** reimbursement policies are based on our review of:

- The Centers for **Medicare** and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of dental practice and
- The views of **providers** and **dentists** practicing in the relevant clinical areas

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

## Replacement rule

Some **eligible dental services** are subject to your plan's replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

These **eligible dental services** are covered only when you give us proof that:

- While you were covered by the plan:
  - You had a tooth (or teeth) extracted after the existing denture or bridge was installed.
  - As a result, you need to replace or add teeth to your denture or bridge.
- The present item cannot be made serviceable, and is:
  - A crown installed at least 8 years before its replacement.
  - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic item installed at least 8 years before its replacement.
- While you were covered by the plan:
  - You had a tooth (or teeth) extracted.
  - Your present denture is an immediate temporary one that replaces that tooth (or teeth).
  - A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

## Tooth missing but not replaced rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 10 years. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

**The Rocky Vista University Dental® Preferred Provider Organization (PPO) Student Dental Plan is underwritten and administered by Aetna Life Insurance Company (ALIC).** Aetna Student Health℠ is the brand name for products and services provided by these companies and their applicable affiliated companies.

**IMPORTANT NOTICES:**

- **Notice of Non-Discrimination:**
  **Aetna Life Insurance Company** does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.

- **Sanctioned Countries:**
  If coverage provided under this student policy violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for eligible health services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

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).

*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

To access language services at no cost to you, call (866) 376-7450.
Para acceder a los servicios de idiomas sin costo, llame al (866) 376-7450. (Spanish)
如欲使用免費語言服務，請致電 (866) 376-7450。(Chinese)
Afin d'accéder aux services langagiers sans frais, composez le (866) 376-7450Click here to enter text.. (French)
Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa (866) 376-7450. (Tagalog)
Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie (866) 376-7450 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 376-7450 (866). (Arabic)

Pou jwenn sèvis lang gratis, rele (866) 376-7450. (French Creole-Haitian)
Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero (866) 376-7450. (Italian)

言語サービスを無料でご利用いただくには、(866) 376-7450 までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 (866) 376-7450 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-###-#### تماس بگیرید. (Persian-Farsi)

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