AETNA LIFE INSURANCE COMPANY PO Box 981206 El Paso, TX 79998

02/26/2018

For more information on the Affordable Care Act or the Individual Shared Responsibility Provision, visit IRS.gov More questions? Contact Member Services at the number in Box 18.

GANESHKUMAR DORAISAMY 13836 JEFFERSON PARK DRIV APT 9304 HERNDON, VA 20171

Form 1095-B (2017)

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse (if you file a joint return), and individuals you claim as dependents had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who don't have minimum essential coverage and don't gualify for an exemption from this requirement may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage. For more information on the requirement to have minimum essential coverage and what is minimum essential coverage, see www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision.



request it for their records.

Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, the premium tax credit, and the employer shared responsibility provisions, see www.irs.gov/Affordable-Care-Act/Individualsand-Families or call the IRS Healthcare Hotline for ACA questions (1-800-919-0452).

Part I. Responsible Individual, lines 1-9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.



If you don't provide your SSN or other TIN and the SSNs or other TINs of all covered individuals to the sponsor of the coverage, the CAUTION IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage



If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange) that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see https://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-about-Health-Care-Information-Forms-for-Individuals.

Line 9. Reserved.

Part II. Information about Certain Employer-Sponsored Coverage, lines **10-15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

Part III. Issuer or Other Coverage Provider, lines 16-22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.

Part IV. Covered Individuals, lines 23-28. This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if an SSN or other TIN isn't entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

In COST-B In control of generation Image: Control of generation <thimage: control="" gene<="" of="" th=""><th>1005 P</th><th colspan="5">EISSUED STATEMENT</th><th></th><th colspan="3">VOID</th><th colspan="3">OMB. No. 1545-2252</th></thimage:>	1005 P	EISSUED STATEMENT						VOID			OMB. No. 1545-2252							
International Services Image: Control work in gov Form 10955 for instructions and the latest information. 1 Revel of responsible individual Tracking #:: 92950514 1 State of perponsible individual 2 Social security number ISN or other TN is not available). 3 Date of thick (ISSN or other TN is not available). 4 State of province 7 Country and 2P or foreign postal cools 336.01 Effect index (individual generation in the least individual generation individual generation in the least individual generation individual indindividual individual	Form 1095-B		► Do not at	Health Coverage attach to your tax return. Keep for your records.											2017			
1 Name of responsible individual 2 Social security number (SN) or other TN 2 Date of thirth of SNN or other TN 4 State additues literaturing partment (tric) 5 City or town 6 State or province 7 Country and 2P or foreign postal code 1 Name of covered Individuals Part VI VA US 20171 9 Teacher TN 9 Ender letter identifying Origin of the Health Coverage (see instructions 19 Teacher TN VA US 20171 9 Ender letter identifying Origin of the Health Coverage (see instructions) 19 Teacher TN 11 Employment entification number (EN) 9 Ender letter identifying Origin of the Health Coverage (see instructions) 13 City or town 14 State or provine 15 Country and 2P or foreign postal code 12 Street eddress lincolding room or suite no.1 13 City or town 14 State or provine 15 Country and 2P or foreign postal code 13 Diry or team 12 Employment entification number (EN) 14 State or provine 15 Country and 2P or foreign postal code 14 State or provine 12 Employment entification number (EN) 16 Context blackhouse enther 10 Dir proving 12 Enter the information for cade code code individual.) 10 Code (State code code code code code code code cod		Go to www.irs.gov.																
CANSSINUMAR XXXXX<0509 4 Storet address functionaling seamments) 5 City or toon 6 States or province 7 Country and 20° or foreign postal code 13335 IEFFERSON PARK DRIV HENNDON 9 Amound 9 Amound US 20171 4 Enter table indentifying Origin of the Health Coverage (see instructions) 9 Amound 9 Amound 10 Enclosed 11 Employer advection number (ENI) 70 Enclose and tables including common or sub enclose 13 City or town 14 State or province 14 Country and 20° or foreign postal code 710 Enclose and tables including common or sub enclose 13 City or town 14 State or province 14 Country and 20° or foreign postal code 72 Country and 20° or foreign postal code TX US 75234 72 Enclose and tables including common or sub enclose 10 Enclosed and tables 10 Enclosed and tables 73 Country and 20° or foreign postal code TX US 75234 74 One country and end tables 10 Enclosed and tables 10 Enclosed and tables 75 Bales or provider (see instructions) 14 State or province 25 State or counter and tables 76 Country and 20° or or sub enclosed and tables 10 Country and 20° or foreign postal code 25 State or province 76 Ano May State or coverage function con or sub enclosed<				Track	ing #:	/ _ /												
4 State address including apartment no.] 5 City or Lown 6 State or province 7 Country and ZP* or foreign postal code 13836 IFFERSION PARK DRIV HERNDON VA US 20171 8 Enter letter identifying Origin of the Health Coverage (see instructions for code):						2	2 Social security number (SSN) or other TIN					3 Date of birth (if SSN or other TIN is not available)						
1336 JEFFERSON PARK DRIV APT 9304 VA US 20171 9 Enter letter identifying Origin of the Health Coverage (see instructions for codes): > > 19 Employeer state: identifying Origin of the Health Coverage (see instructions) 11 Employeer identification number (EIN) XXXXX5735 > 12 Street address including room or suite no.1 13 City or town 14 State or province 11 Employeer identification number (EIN) XXXXX5735 12 Street address including room or suite no.1 13 City or town 14 State or province 15 Country and ZP or foreign postal code 3010 L.B.J. FREEWAY, SUITE 400 DALLAS TX US 75224 Park III Issuer or Other Coverage Provider (see instructions) 12 Employer identification number (EIN) 18 Contact biophone number 19 Streat defensional runnal of the information for each covered individual). 12 Employer identification number (EIN) 12 Contact address of the postal code 19 Streat defensional runnal runnal of the information for each covered individual). 12 Employer identification number (EIN) 13 Contact biophone number 19 Covered Individuals (Enter the information for each covered individual) 14 Covered 14 Covered 19 Covered 12 Covered Individuals 10 SN or other IN 14 Covered 10 Months of soverage 2 GANESHKUMAR XXX-XX-XXX 2003-01-15 14 Covered 10 Months of soverage 24 GANESHKUMAR XXX-X			T															
APT 9304 HERNDON V.A US 20171 a Entrie Inter Int				5 City or town			6 State or province					7 Country and ZIP or foreign postal code						
9 Enter letter identifying Origin of the Health Coverage (see instructions for codes):																		
e Ener letter identifying Origin of the Health Coverage ises instructions for codesi:	APT 9304			HERNDON								US 20171						
10 Employer name TAC) TATA AMERICAN INTERNATIONAL CORPO 11 Employer dentification number (ENI XXXXX578 12 Street address (including room or suite no.) 13 City or town 14 State or province 15 Country and 2P or foreign postal code 3010 L.B.J. PREEWAY, SUITE 400 DAILAS TX US 75234 Table Issuer or Other Coverage Provider (see instructions) 14 State or province 18 Country and 2P or foreign postal code 19 Street address (including room or suite no.) 20 City or town 21 State or province 22 Country and 2P or foreign postal code PO Box 981206 E1 Pasco TX US 79998 Part IV Covered Individuals (Enter the information for each covered individual) (e) Covered individuals (Enter the information for each covered individual) 12 Provints (e) Months of covereage GANESHKUMAR XXX-XX-XX0509 X 11 Energine Provints (e) Months of covereage 24 GANESHKUMAR XXX-XX-XXXX 1976-12-20 X 11 11 11 11 25 GANESHKUMAR XXX-XX-XXXX 2003-01-15 X 11	8 Enter letter identifying Orig	in of the Health Cover	age (see instructions	s for codes):	· · · . ▶ <u>I</u>	3	neserved	1										
XXXXX5758 XXXXX5758 XXXXX5758 XXXXX5758 XXXXX758 XXXXX758 XXXXX758 XXXXX758 XXXXX758 XXXXX758 XXXXX758 XXXXX758 XXXXX778 XXXXX78 XXXXX78 XXXXX78 XXXXX78 XXXXX78 XXXXX78 XXXXX78 XXXXX78 XXXXX78 XXXXXXXX78 XXXXXXXX78 XXXXXXXXX78 XXXXXXXXX78 XXXXXXXX78 XXXXXX78 XXXXXX78 XXXXXX78 XXXXXX78 XXXXXX78 XXXXX78 XXXXX78 XXXXXX78 XXXXXX78 <td>Part II Information A</td> <td>About Certain Em</td> <td>ployer-Sponsor</td> <td>ed Coverage (s</td> <td>ee instructio</td> <td>ons)</td> <td></td>	Part II Information A	About Certain Em	ployer-Sponsor	ed Coverage (s	ee instructio	ons)												
12 Street address (including room or suite no.) 13 City or town 14 State or province 15 Country and ZIP or foreign postal code 2010 L.B.J. FREEWAY. SUTE 400 DALLAS TX US 7524 Part III Issuer or Other Coverage Provider (see instructions) 17 Employer/dentification number (EIN) 18 Contact telephone number 19 Street address (including room or suite no.) 20 City or town 21 State or province 22 Country and ZIP or foreign postal code PO Box 981206 EI Paso TX US 79998 Part W Covered Individuals [b) SN or other TIN (d) Covered (a) Name of covered individuals(s) (b) SN or other TIN (d) Covered (d) Covered 23 DORALSHKUMAR XXX-XX-0509 X (d) Covered (e) Monthe of coverage 24 GANESHKUMAR XXX-XX-XXXX 1976-12-20 X (a) Covered (a) Covered 24 GANESHKUMAR XXX-XX-XXXX 200-01-15 X (a) Covered (a) Covered (a) Covered 25 GANESHKUMAR XXX-XX-XXXX 1976-12-20 X (a) Covered (a) Covered (a) Covered 25 GANESHKUMAR XXX-XX-XXXX 2010-09-11 (a) Covered (a) Covered	10 Employer name (TAIC) TATA AMERICAN INTERNATIONAL			, CORPO						1								
S010 L.B.J. FREEWAY, SUITE 400 DALLAS TX US 75234 16 Name 17 Employer/dentification number (EIN) 18 Contact telephone number 16 Name 06-6033492 25-531-6837 19 Street address lineluding room or suite no.) 20 City or town 21 State or province 22 Country and 2IP or foreign postal code 19 Street address lineluding room or suite no.) 20 City or town 21 State or province 22 Country and 2IP or foreign postal code 19 Street address lineluding room or suite no.) 20 City or town 21 State or province 22 Country and 2IP or foreign postal code 19 Street address lineluding room or suite no.) EI Paso TX US 79998 22 country and ZIP or foreign postal code EI Paso TX US 79998 23 DOR ASS 20 Cobered Individual(s) (b) SSN or other TIN (c) OB (ff SSN or																		
In Susuer or Other Coverage Provider (see instructions) 17 Employer identification number (EN) 18 Contact telephone number S55-531-6837 19 Street address (including room or suite no.) 20 City or town 21 State or province 22 Country and ZIP or foreign postal code PO Box 981206 T US 79998 Port IV Covered Individuals (Enter the information for each covered individual.) (a) Name of covered individual(s) (b) SN or other TN (d) DOB (if SNor other TN is not or other TN is nother TN is not or other TN is not or other TN is n	12 Street address (including room or suite no.)			13 City or town			14 State or province					15 Country and ZIP or foreign postal code						
In Susuer or Other Coverage Provider (see instructions) 17 Employer identification number (EN) 18 Contact telephone number S55-531-6837 19 Street address (including room or suite no.) 20 City or town 21 State or province 22 Country and ZIP or foreign postal code PO Box 981206 T US 79998 Port IV Covered Individuals (Enter the information for each covered individual.) (a) Name of covered individual(s) (b) SN or other TN (d) DOB (if SNor other TN is not or other TN is nother TN is not or other TN is not or other TN is n				D. H. H. G.														
16 Name 17 Employeridentification number (EIN) 18 Contact telephone number Actna Life Insurance Company 06-6033492 855-531-6837 19 Street address (including room or suite no.) 20 City or town 21 State or province 22 Country and ZIP or foreign postale code PO Box 981206 EI Paso TX US 79998 Part IV Covered Individuals (Enter the information for each covered individual.) (e) Months of coverage (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other TIN evaluation for each covered individual.) (a) Covered individual(s) (b) SSN or other TIN evaluation for each covered individual.) GANESHKUMAR XXX-XX-0509 X (a) Covered individual(s) (b) SSN or other TIN evaluation for each covered individual.) RASHEEDA XXX-XX-0509 X (a) Covered individual(s) (b) SSN or other TIN evaluation for each covered individual(s) RASHEEDA XXX-XX-XXXX 1976-12-20 X (a) Covered individual(s) (b) Covered individual(s) AASHISH XXX-XX-XXXX 2003-01-15 X (c) Covered individual(s) (c) Covered individual(s) 24 GANESHKUMAR XXX-XX-XXXX 2003-01-15 X (c) Covered indicividual(s) (c) Covered indivi		vider (see instru								<u>US 75234</u>								
Actna Life Insurance Company 06-6033492 855-531-6837 19 Street address (Including room or suite no.) 20 City or town 21 State or province 22 Country and ZIP or foreign postal code PO Box 981206 El Paso TX US 79998 Part IV Covered Individuals (Enter the information for each covered individual.) (e) Months of coverage (a) Name of coverad individual(s) (b) SN or other TN (e) DOB (if SN or other TN is not available) (e) Months of coverage 23 DORALSAMY XXX-XX-0509 XX Q<		er ooverage i tov		clions		17	Employe	ridentific	ation num	ber (EIN)	1	8 Contac	t telepho	ne numbe	er			
19 Street address (including room or suite no.) 20 City or town 21 State or province 22 Country and 2/P or foreign postal code PO Box 981206 EI Paso Tx US 79998 Port IV Covered Individuals (Enter the information for each covered individual.) (d) Covered (d) Covered (d) Covered (a) Name of covered individual(s) (b) SN or other TIN (c) DOB (If SN or other TIN or other TIN in all 12 months) (d) Covered (d) Covered (a) Name of covered individual(s) (b) SN or other TIN (c) DOB (If SN or other TIN or other TIN in all 12 months) (d) Covered (d) Covered (a) Additional ST (Covered Individual(s) (b) SN or other TIN (c) DOB (If SN or other TIN in all 12 months) (d) Covered (e) Months of coverage (a) Additional ST (Covered Individual(s) (b) SN or other TIN (c) DOB (If SN or other TIN in all 12 months) (d) Covered (e) Months of coverage (a) CALL (b) SN or other TIN (c) DOB (If SN or other TIN in all 22 months) (d) Covered (e) Months of coverage (a) CALL (b) SN or other TIN (c) DOB (If SN or other TIN (c) CALL (c) CALL (c) CALL (c) CALL (a) CALL (b) SN or other TIN (c) CALL (c) CALL (c) CALL <th< td=""><td colspan="3">Aetna Life Insurance Company</td><td colspan="3"></td><td colspan="5"></td><td colspan="6"></td></th<>	Aetna Life Insurance Company																	
Part IV Covered Individuals (Enter the information for each covered individual.) (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (ff SSN or other available) (a) Covered and individual(s) (c) Months of coverage GANESHKUMAR (b) SSN or other TIN (c) DOB (ff SSN or other available) (c) DOB (ff SSN or other available) (c) Covered and individual(s) (c) Months of coverage GANESHKUMAR XXX-XX-0509 III 2 months (c) III 2 months (c) III 2 months (c) III 2 months RASHEEDA XXX-XX-0509 IX III III III III 2 months III III III III III III III IIII III I				20 City or town							2							
Part IV Covered Individuals (Enter the information for each covered individual.) (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (ff SSN or other available) (a) Covered and individual(s) (c) Months of coverage GANESHKUMAR (b) SSN or other TIN (c) DOB (ff SSN or other available) (c) DOB (ff SSN or other available) (c) Covered and individual(s) (c) Months of coverage GANESHKUMAR XXX-XX-0509 III 2 months (c) III 2 months (c) III 2 months (c) III 2 months RASHEEDA XXX-XX-0509 IX III III III III 2 months III III III III III III III IIII III I																		
(a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other TIN is not available) (d) Covered all 12 months (e) Months of coverage Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec GANESHKUMAR XXX-XX-0509 X Image: Control of the time time time time time time time tim	PO Box 981206							US 79998										
other TIN is not available) all 12 months all 12 months all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec GANESHKUMAR XXX-XX-0509 IX III IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Part IV Covered Indi	viduals (Enter the	information for	each covered in	ndividual.)													
available) Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec GANESHKUMAR XXX-XX-0509 XX XX Image: Asset to the stress of the stres	(a) Name of covered i	(b) SSN or other TIN				(e) Months of coverage												
GANESHKUMAR XXX-XX-0509 X I					all 12 months	1					Luna							
23 DORAISAMY XXX-XX-0509 Image: Constraint of the second sec						Jan	Feb	iviar	Apr	iviay	June	July	Aug	Sept	Uct	INOV	Dec	
23 DORAISAMY XXX-XX-0509 Image: Constraint of the second sec	CANESHVIMAD				v													
RASHEEDA XXX-XX-XXXX 1976-12-20 IX II II II III IIII IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			XXX-XX-0509															
24 GANESHKUMAR XXX-XX-XXXX 1976-12-20 Image: Constraint of the second sec			<u>AAA-AA-0309</u>															
24 GANESHKUMAR XXX-XX-XXXX 1976-12-20 Image: Constraint of the second sec	RASHEEDA				X													
25 GANESHKUMAR XXX-XX-XXXX 2003-01-15 Image: Constraint of the second sec			XXX-XX-XXX	X 1976-12-20														
25 GANESHKUMAR XXX-XX-XXXX 2003-01-15 Image: Constraint of the second sec																	[
AADHISH XXX-XX-XXX 2010-09-11 X I <thi< th=""> I<!--</td--><td></td><td></td><td></td><td></td><td>X</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></thi<>					X													
26 GANESHKUMAR XXX-XX-XXXX 2010-09-11 Image: Comparison of the second sec	25 GANESHKUMAR		XXX-XX-XXX	X 2003-01-15														
26 GANESHKUMAR XXX-XX-XXXX 2010-09-11 Image: Comparison of the second sec																		
27				2010 00 11														
	26 GANESHKUMAR		XXX-XX-XXX	X 2010-09-11														
	27																	
28																		
28																		
	28																	

TTY:711

English	To access language services at no cost to you, call the number on your ID card.					
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.					
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.					
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.					
Chinese Traditional	如欲使用免費語言服務,請撥打您健康保險卡上所列的電話號碼					
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.					
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.					
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.					
Amharic	የቋንቋ አንልግለሞችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለወን ቁጥር ይደወሉ፡ ፡					
Urdu	کارڈ پر درج نمبر پر 団لسانی خدمات تک مُفت رسائی کے لیے، اپنے بیمہ کے کال کریں۔					
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.					
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.					
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।					
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.					
Bengali	আপনাকে বিনামূল্যে ভাষা পরিষেবাপেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করু না					
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obụla, kpọọ nọmba nọ na kaadi njirimara gị					
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla					
Yoruba	Láti ráyèsí àwọn işệ èdè fún ọ lófệẹ, pe nómbà tó wà lórí káàdì ìdánimò rẹ.					

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide 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.