**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, go online at https://eoc.anthem.com/eocdps/aso (Anthem), www.HealthReformPlanSBC.com (Aetna) or www.cigna.com/sp (CIGNA). 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 (877) 898-0747 (Anthem), (877)-350-7923 (Aetna) or 1-800-Cigna24 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For in-network providers: **$900**/individual or **$1,800**/family<br>For out-of-network providers: **$3,000**/individual or **$6,000**/family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. In-network preventive care & immunizations, office visits | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For in-network providers **$3,000**/individual or **$6,000**/family<br>For out-of-network providers **$6,000**/individual or **$12,000**/family<br>Combined medical/behavioral and pharmacy out-of-pocket limit | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso, https://www.aetna.com or https://www.cigna.com..

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See Anthem Blue Card PPO, **www.anthem.com** or call **877-898- 0747;** Aetna Choice® POS II, **www.aetna.com/docfind** or call **1-888-982-3862;** Open Access Plan, **www.myCigna.com** or call **1-800-Cigna24,** for a list of network providers. | 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. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $40 copay/visit<br>Deductible does not apply | 40% coinsurance | None |
| | Specialist visit | $80 copay/visit<br>Deductible does not apply | 40% coinsurance | None |
| | Preventive care/ screening/ immunization | No charge/visit**<br>No charge/screening**<br>No charge/immunizations**<br>**Deductible does not apply | 40% coinsurance/visit<br>40% coinsurance/screening<br>40% coinsurance/ immunizations | None<br>None<br>None<br>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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | None |

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso, https://www.aetna.com or https://www.cigna.com

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider (You will pay the least) | What You Will Pay<br>Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about prescription drug coverage is available at www.caremark.com | Generic drugs (Tier 1) | Retail $10 copay/Mail Order $25 | Retail only: $10 copay plus difference between cost of the drug and CVS negotiated price | Carved out to CVS/Caremark<br><br>Deductible does not apply<br><br>Rx costs accumulate toward the Out of Pocket Plan Max |
| | Preferred brand drugs (Tier 2) | 30% coinsurance<br>Retail ($25 min, $50 max)/Mail Order ($62.50 min, $125 max) | Retail only: 30% coinsurance ($25 min, $50 max) plus difference between cost of the drug and CVS negotiated price | |
| | Non-preferred brand drugs (Tier 3) | 45% coinsurance<br>Retail ($40 min, $80 max)/Mail Order ($100 min, $200 max) | Retail only: 45% coinsurance ($40 min, $80 max) plus difference between cost of the drug and CVS negotiated price | |
| | Specialty drugs (Tier 4) | Subject to applicable copays/coinsurance based on preferred or non-preferred status | Subject to applicable copays/coinsurance, plus difference between cost of the drug and CVS negotiated price | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | 20% coinsurance | 20% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | $500 penalty for no precertification. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | $500 penalty for no precertification. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $40 copay/office visit**<br>20% coinsurance/all other services<br>**Deductible does not apply | 40% coinsurance/office visit<br>40% coinsurance/all other services | None |
| | Inpatient services | 20% coinsurance | 40% coinsurance | $500 penalty for no precertification. |

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso, https://www.aetna.com or https://www.cigna.com

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider (You will pay the least) | What You Will Pay<br>Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you are pregnant** | Office visits | $40 first visit to confirm pregnancy; then 100% coverage | 40% coinsurance | Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.<br>Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Coverage is limited to 120 days annual max. (The limit is not applicable to mental health and substance use disorder conditions.) |
| | Rehabilitation services | $40 copay/PCP visit**<br>$80 copay/Specialist visit**<br>**Deductible does not apply | 40% coinsurance/PCP visit<br>40% coinsurance/Specialist visit | *Coverage is limited to annual max of: 30 days for Chiropractic care services |
| | Habilitation services | $80 copay<br>**Deductible does not apply | 40% coinsurance | *See therapy services section |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | $500 penalty for no precertification. Coverage is limited to 120 days annual max. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | None |
| | Hospice services | 20% coinsurance/inpatient or outpatient services | 40% coinsurance/inpatient or outpatient services | $500 penalty for no precertification. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso, https://www.aetna.com or https://www.cigna.com

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Dental Check-up
- Eye care (Children)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless diagnosed with diabetes
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture
- Bariatric Surgery (in-network only Surgeon Charges Lifetime max $25,000)
- Chiropractic care (30 days)
- Hearing aids (2 devices every three Calendar Years)
- Infertility treatment (Lifetime max $15,000)

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso, https://www.aetna.com or https://www.cigna.com

### 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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 questions about your rights, this notice, or assistance, you can call 877-898-0747 (Anthem), 877-350-7923 or http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html. (Aetna) or Cigna Customer service at 1-800-Cigna24. 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. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Department of Financial Services at (800) 342-3736. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

**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 the 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.

----------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** **$900**
- **Specialist copayment** **$80**
- **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:**

| Cost Sharing | |
|---|---|
| Deductibles | $900 |
| Copayments | $40 |
| Coinsurance | $2,100 |
| What isn't covered | |
| Limits or exclusions | $10 |
| **The total Peg would pay is** | **$3,050** |

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

- **The plan's overall deductible** **$900**
- **Specialist copayment** **$80**
- **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:**

| Cost Sharing | |
|---|---|
| Deductibles | $130 |
| Copayments | $300 |
| Coinsurance | $1200 |
| What isn't covered | |
| Limits or exclusions | $200 |
| **The total Joe would pay is** | **$1,830** |

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

- **The plan's overall deductible** **$900**
- **Specialist copayment** **$80**
- **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:**

| Cost Sharing | |
|---|---|
| Deductibles | $900 |
| Copayments | $200 |
| Coinsurance | $100 |
| What isn't covered | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,200** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

## Language Access Services: (TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA)

**Amharic (አማርኛ)፦** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA)ይደውሉ።

**Arabic** (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA)

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA):

**Bassa (Bǎsɔ̀ɔ̀ Wùdù):** Ǹ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bèdɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA) -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA) သို့ ခေါ်ဆိုပါ။

**Chinese (中文)**：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA)。

**Dinka (Dinka):** Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

**Farsi** (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره‌ماس بگیرید. (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA)

**French (Français) :** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

## Language Access Services: (TTY/TDD: 711)

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

**Greek (Ελληνικά)** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको नि:शुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA) ।

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

**Igbo (Igbo):** Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

**Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

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**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA) ។

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

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## Language Access Services: (TTY/TDD: 711)

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA)

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**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA)

**Oromo (Oromifaa):** Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA) bilbilla.

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**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA) ਤੇ ਕਾਲ ਕਰੋ।

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## Language Access Services: (TTY/TDD: 711)

**Thai (ไทย):** หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA)เพื่อพูดคุยกับล่าม

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