

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services  
**Pearson, Inc.: \$400 Deductible PPO**

**Coverage Period:** 01/01/2020 - 12/31/2020  
**Coverage for:** Individual/Individual + Family | **Plan Type:** PPO



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](http://www.HealthReformPlanSBC.com) (Aetna) or [www.cigna.com/sp](http://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 <a href="#">deductible</a> ?	For <a href="#">in-network providers</a> : <b>\$400</b> /individual or <b>\$800</b> /family For <a href="#">out-of-network providers</a> : <b>\$2,500</b> /individual or <b>\$5,000</b> /family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. In-network <a href="#">preventive care</a> & immunizations, office visits, in-network <a href="#">urgent care</a> facility visits.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">in-network providers</a> <b>\$2,200</b> /individual or <b>\$4,400</b> /family For <a href="#">out-of-network providers</a> <b>\$4,400</b> /individual or <b>\$8,800</b> /family Combined medical/behavioral and pharmacy <a href="#">out-of-pocket limit</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Penalties for failure to obtain <a href="#">pre-authorization</a> for services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

\* 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 <a href="#">network provider</a> ?	Yes. See Anthem Blue Card PPO, <a href="http://www.anthem.com">www.anthem.com</a> or call 877-898-0747; Aetna Choice® POS II, <a href="http://www.aetna.com/docfind">http://www.aetna.com/docfind</a> or call 1-888-982-3862; Open Access Plan, <a href="http://www.myCigna.com">www.myCigna.com</a> or call 1-800-Cigna24, for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/ screening/ immunization</a>	No charge/visit** No charge/screening** No charge/immunizations**  ** <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a> /visit 40% <a href="#">coinsurance</a> /screening 40% <a href="#">coinsurance</a> /immunizations	None None None
				You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="http://www.caremark.com">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs (Tier 1)	\$10 Retail / \$25 Mail Order	Retail only: applicable tier copay plus the difference between cost of the drug and CVS negotiated price	Carved out to CVS/Caremark  Deductible does not apply  Rx costs accumulate toward the Out of Pocket Plan Max
	Preferred brand drugs (Tier 2)	\$30 Retail / \$75 Mail Order		
	Non-preferred brand drugs (Tier 3)	\$60 Retail / \$150 Mail Order		
	<a href="#">Specialty drugs</a> (Tier 4)	Subject to applicable copays based on preferred or non-preferred status	Subject to applicable copays plus the difference between cost of the drug and CVS negotiated price	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> /visit after deductible	\$150 <a href="#">copay</a> /visit after deductible	Per visit <a href="#">copay</a> is waived if admitted
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	\$50 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$500 penalty for no precertification.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$500 penalty for no precertification.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <a href="#">copay</a> /office visit** 20% <a href="#">coinsurance</a> /all other services ** <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a> /office visit 40% <a href="#">coinsurance</a> /all other services	None
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$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		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	\$20 first visit to confirm pregnancy; then 100% coverage	40% <a href="#">coinsurance</a>	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Coverage is limited to 120 days annual max. (The limit is not applicable to mental health and substance use disorder conditions.)
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> /PCP visit** \$40 <a href="#">copay</a> /Specialist visit** ** <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a> /PCP visit 40% <a href="#">coinsurance</a> /Specialist visit	*Coverage is limited to annual max of: 30 days annual max for Chiropractic care services
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /Specialist visit** ** <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	*See therapy services section
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$500 penalty for no precertification. Coverage is limited to 120 days annual max.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> /inpatient; 20% <a href="#">coinsurance</a> /outpatient services	40% <a href="#">coinsurance</a> /inpatient; 40% <a href="#">coinsurance</a> /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       | • Glasses (Child)                                    | • Private-duty nursing     |
| • Dental care (Adult)    | • Long-term care                                     | • Routine eye care (Adult) |
| • Dental care (Children) | • Non-emergency care when traveling outside the U.S. | • Routine foot care        |
| • Dental Check-up        |  | • Weight loss programs     |
| • Eye care (Children)    |  |                            |

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

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

\* 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](http://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](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 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](http://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](http://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](#) \$400
- [Specialist copayment](#) \$40
- 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)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$400
Copayments	\$20
Coinsurance	\$1,600

What isn't covered	
Limits or exclusions	\$30

<b>The total Peg would pay is</b>	<b>\$2,050</b>
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### Managing Joe's type 2 Diabetes (a

year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$400
- [Specialist copayment](#) \$40
- 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)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

Cost Sharing	
Deductibles	\$130
Copayments	\$200
Coinsurance	\$0

What isn't covered	
Limits or exclusions	\$6,200

<b>The total Joe would pay is</b>	<b>\$6,530</b>
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### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$400
- [Specialist copayment](#) \$40
- 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)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

Cost Sharing	
Deductibles	\$400
Copayments	\$300
Coinsurance	\$50

What isn't covered	
Limits or exclusions	\$0

<b>The total Mia would pay is</b>	<b>\$750</b>
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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።

(877) 898-0747 (Anthem),

(888) 982-3862 (Aetna),

(800) 244-6224 (CIGNA)

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على

**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 (Bàsɔ̀ wùdù):** M̃ dyi dyi-diè-dě bě bédé bá cèè-dě nìà kɛ dyí ní, ɔ̀ mò nì dyí-bédèìn-dě bɛ̀ m̃ kɛ gbo-kpá-kpá kè bʋ́ kpɔ́ dɛ̀ m̃ bídɪ́-wùdùùn bó pídyi. Bɛ̀ m̃ kɛ wuɖu-zììn-nyò dò gbo wùdù kɛ, d́á (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 အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), သို့ ခေါ်ဆိုပါ။ (800) 244-6224 (CIGNA)

**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 nōŋ thiëc nē ke de yā thorē, ke yin nōŋ loŋ bē yi kuony ku wēr alēu bē gēer yic yin ne thoŋ du ke cin wēu tāäuē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin cōl (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 (فارسی):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای 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 निःशुल्क 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):** O bụr ụ na ị nwere ajujụ o bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ o 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).

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**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

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**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។

ដើម្បីជ្រើសរើសអ្នកបកប្រែ សូមហៅ (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA) ។

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

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee níl hodoonih t'áadoo bááh ílinígóó. Ata' halne'ígíí lá' bich'í' hadeesdzih nínízingo kojí' hodiílnih (877) 898-0747 (Anthem), (888) 982-3862 (Aetna), (800) 244-6224 (CIGNA).

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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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