



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, contact Sutter Health Plus at 1-855-315-5800 or visit sutterhealthplus.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment (copay), deductible, provider, or other underlined terms, see the Glossary of Health Coverage and Medical Terms. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-855-315-5800 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,500 individual / \$3,000 individual family member / \$5,000 family for certain medical and pharmacy services per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Only <u>preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> (copay) or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$7,050 individual / \$7,050 individual family member / \$14,100 family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , health care this <u>plan</u> doesn't cover and <u>cost sharing</u> for infertility treatment and all optional benefits if elected by your employer group.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Will you pay less if you use a <u>network provider</u>?	Yes. See www.sutterhealthplus.org/provider-search or call 1-855-315-5800 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 All copayment (copay) 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
		Participating Provider	Non-Participating Provider	
If you visit a health care <u>provider's office</u> or clinic	<u>Primary Care Physician</u> (PCP) Visit to treat an injury or illness	\$35 copay per visit	Not covered	Includes Other Health Professional and Sutter Walk-in Care visits. *See Definitions section in EOC for list of Other Health Professionals.
	<u>Specialist</u> Visit	\$50 copay per visit	Not covered	Prior authorization for some <u>referrals</u> to <u>specialists</u> is required. If it is not received, you may be responsible for paying all charges.
	<u>Preventive Care</u> / <u>Screening</u> / Immunization	No charge <u>Deductible</u> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic Test</u> (X-ray, blood work)	Lab: \$35 copay per visit X-ray: \$15 copay per procedure	Not covered	Prior authorization for some diagnostic services is required. If it is not received, you may be responsible for paying all charges.
	Imaging (CT/PET scans, MRIs)	\$50 copay per procedure	Not covered	

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at www.sutterhealthplus.org/about/plans-benefits or call 1-855-315-5800.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
<p>If you need drugs to treat your illness or condition For information about <u>prescription drug coverage</u>, including the Sutter Health Plus (SHP) <u>formulary</u>, visit www.sutterhealthplus.org/pharmacy or call CVS Caremark® at 1-844-740-0635.</p>	Tier 1 (Most generic drugs and low-cost preferred brand name drugs)	Retail: \$20 copay per prescription Mail Order: \$40 copay per prescription	Not covered	Retail: covers up to a 30-day supply through a CVS Health® National Network pharmacy and covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through a CVS retail pharmacy that participates in the Retail-90 Network.
	Tier 2 (Preferred brand name drugs and non-preferred generic drugs)	Retail: \$40 copay per prescription Mail Order: \$80 copay per prescription	Not covered	Mail Order/home delivery service: covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through the CVS Caremark® Mail Service Pharmacy. Specialty Pharmacy: covers up to a 30-day supply of <u>specialty drugs</u> through CVS Specialty®. <u>Specialty drugs</u> are not exclusive to Tier 4 and, regardless of tier placement, have the same fill requirements.
	Tier 3 (Non-preferred brand name drugs)	Retail: \$60 copay per prescription Mail Order: \$120 copay per prescription	Not covered	<u>Cost sharing</u> for drugs prescribed for the treatment of infertility is 50% <u>coinsurance</u> and does not apply to your <u>deductible</u> , if applicable, and <u>out-of-pocket limit</u> .
	Tier 4 (<u>Specialty drugs</u>)	Specialty Pharmacy: 25% <u>coinsurance</u> up to \$250 per prescription	Not covered	*See SHP <u>formulary</u> or the Outpatient <u>Prescription Drugs</u> , Supplies, Equipment and Supplement section in EOC for any SHP policy requirements such as prior authorization and step therapy, or coverage limitations and exceptions.

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at www.sutterhealthplus.org/about/plans-benefits or call 1-855-315-5800.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
If you have outpatient surgery	Facility Fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	Not covered	Prior authorization is required. If it is not received, you may be responsible for paying all charges.
	Physician / Surgeon Fee	25% <u>coinsurance</u>	Not covered	
If you need immediate medical attention	<u>Emergency Room Care</u>	Facility: 25% <u>coinsurance</u> Professional: No charge		If admitted to the hospital, <u>Emergency Room Care cost sharing</u> will not apply. See hospital stay information below for applicable <u>cost sharing</u> .
	<u>Emergency Medical Transportation</u>	25% <u>coinsurance</u>		Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van) is not covered.
	<u>Urgent Care</u>	\$35 copay per visit		None
If you have a hospital stay	Facility Fee (e.g., hospital room)	25% <u>coinsurance</u>	Not covered	Prior authorization is required. If it is not received, you may be responsible for paying all charges.
	Physician / Surgeon Fees	25% <u>coinsurance</u>	Not covered	
If you need mental health, behavioral health, or substance use disorder (MH/SUD) services For information, call U.S. Behavioral Health Plan, California (USBHPC) at 1-855-202-0984 or visit www.liveandworkwell.com (access code: "Sutter").	Outpatient Services	Individual Office Visit: \$35 copay per visit Group Office Visit: \$17.50 copay per visit Other Outpatient Services: 25% <u>coinsurance</u>	Not covered	You may self-refer to a USBHPC <u>provider</u> for Office Visits. Prior authorization is required for Other Outpatient Services and all Inpatient Services by USBHPC. If it is not obtained when required, you may be liable for the payment of services or supplies.
	Inpatient Services	Facility: 25% <u>coinsurance</u> Professional: 25% <u>coinsurance</u>	Not covered	
If you are pregnant	Office Visits	Prenatal and Postnatal Care: No charge	Not covered	Prenatal and Postnatal Care includes all prenatal office visits and the first

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		Participating Provider	Non-Participating Provider	
		<u>Deductible</u> does not apply		postnatal office visit. Refer to the PCP Visit <u>cost sharing</u> for all subsequent postnatal office visits. Maternity care may include tests and services described elsewhere in the SBC (e.g., <u>Diagnostic Tests</u> such as ultrasounds and blood work).
	Childbirth / Delivery Professional Services	25% <u>coinsurance</u>	Not covered	None
	Childbirth / Delivery Facility Services	25% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home Health Care</u>	25% <u>coinsurance</u>	Not covered	Prior authorization is required. If it is not received, you may be responsible for paying all charges.
	<u>Rehabilitation Services</u>	\$35 copay per visit	Not covered	Quantitative limits exist for the following services: <u>Home Health Care</u> – 100 visits per calendar year.
	<u>Habilitation Services</u>	\$35 copay per visit	Not covered	<u>Skilled Nursing Care</u> – 100 days per benefit period. *See Skilled Nursing Facility Care section in EOC for additional information.
	<u>Skilled Nursing Care</u>	25% <u>coinsurance</u>	Not covered	<u>Hospice Services</u> – respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time.
	<u>Durable Medical Equipment</u>	25% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> for special footwear and orthotics is 20% <u>coinsurance</u> and does

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
	<u>Hospice Services</u>	No charge	Not covered	apply to your <u>deductible</u> , if applicable, and <u>out-of-pocket limit</u> . *See Special Footwear and Orthotics Benefit Addendum in EOC for additional information.
If your child needs dental or eye care For more information, contact Vision Services Plan (VSP) at 1-800-877-7195 or Delta Dental at 1-800-422-4234.	Children's Eye Exam	No charge <u>Deductible</u> does not apply	Not covered	Quantitative limits exist for the following children's services: Eye Exam – 1 preventive exam per calendar year.
	Children's Glasses	No charge <u>Deductible</u> does not apply	Not covered	Glasses – 1 pair of glasses (or contact lenses in lieu of glasses) per calendar year.
	Children's Dental Check-up	No charge <u>Deductible</u> does not apply	Not covered	Dental Check-up – preventive prophylaxis and diagnostic oral evaluation limited to 1 per 6 months. These are embedded pediatric vision and dental benefits that are provided through the end of the month in which you turn 19 years of age.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your <u>plan</u> Evidence of Coverage (EOC) for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Chiropractic care • Commercial weight loss programs • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Adult) • Routine foot care

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at www.sutterhealthplus.org/about/plans-benefits or call 1-855-315-5800.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan Evidence of Coverage (EOC).)

- Abortion
- Acupuncture typically provided only for the treatment of nausea or chronic pain; embedded in medical plan. PCP referral and prior authorization are required.
- Bariatric surgery
- Infertility treatment embedded in medical plan. A PCP or OB/GYN referral and prior authorization by your medical group or SHP are required for medically necessary services. Cost sharing for infertility treatment is 50% coinsurance and does not apply to your deductible, if applicable, and out-of-pocket limit. *See Infertility Services Benefit Addendum in EOC for additional information.

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: The Department of Managed Health Care at **1-888-466-2219** or www.dmhc.ca.gov, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through California's Health Insurance Marketplace, Covered California, at 1-800-300-1506 or www.coveredca.com. For more information about the Marketplace, visit 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 (*See If You Have A Concern Or Dispute With SHP section in EOC for information about grievances) or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Sutter Health Plus at **1-855-315-5800 (TTY: 1-855-830-3500)** or California Department of Managed Health Care at **1-888-466-2219 (TTY: 1-877-688-9891)** or www.dmhc.ca.gov.

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet the Minimum Value Standards? Not Applicable.

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.

Language Access Services:

Please see Notice of Language Assistance addendum.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at www.sutterhealthplus.org/about/plans-benefits or call 1-855-315-5800.

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 (copays) 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 prenatal care and a hospital delivery)

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

This EXAMPLE event includes services like:

Office Visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services (*anesthesia*)
 Diagnostic Tests (*ultrasounds and blood work*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductible</u>	\$2,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,800
<u>What isn't covered</u>	
Limits or <u>excluded services</u>	\$60
The total Peg would pay is	\$4,370

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

This EXAMPLE event includes services like:

Primary Care Physician Office Visits (*including disease education*)
 Diagnostic Tests (*blood work*)
 Prescription Drugs (*including glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductible</u>	\$2,500
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or <u>excluded services</u>	\$20
The total Joe would pay is	\$3,320

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

This EXAMPLE event includes services like:

Emergency Room Care (*including medical supplies*)
 Diagnostic Tests (*X-ray*)
 Durable Medical Equipment (*crutches*)
 Rehabilitation Services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductible</u>	\$2,500
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or <u>excluded services</u>	\$0
The total Mia would pay is	\$2,580

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

Notice of Language Assistance

IMPORTANT: Can you read this? If not, Sutter Health Plus can have somebody help you read it. You may also be able to get this written in your language. For no-cost help, please call Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plus puede proporcionarle alguien que le ayude a leerlo. También puede obtenerlo por escrito en su idioma. Llame a Sutter Health Plus Member Services al 1-855-315-5800 (TTY 1-855-830-3500), sin costo alguno. (Spanish)

重要提示： 您能讀懂這份文件嗎？如果不能，Sutter Health Plus 可以找人幫助您讀它。您還可
能得到用您的語言書寫的這份文件。若需要免費幫助，請致電 Sutter Health Plus 會員服務，
電話號碼 1-855-315-5800 (TTY 1-855-830-3500)。(Chinese)

ملحوظة مهمة: هل أنت قادر على قراءة هذا؟ إذا لم تكن قادرًا فاعلم أن صتّر هيلث بلاس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنه مساعدتك في قراءة هذا النص. كما يمكنك أيضًا أن تتلقاه مكتوبًا بلغتك. للحصول على مساعدة مجانية، برجاء الاتصال بخدمات أعضاء صتّر هيلث بلاس (Sutter Health Plus Member Services) على هاتف 1-855-315-5800 (هاتف النص المرئي [TTY] 1-855-830-3500). (Arabic)

ԿԱՐԵՎՈՐ ՏԵՂԵԿԱՏՎՈՒԹՅՈՒՆ. Կարո՞ղ եք կարդալ սա: Եթե ոչ, Sutter Health Plus-ը կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն: Դուք կարող եք նաև ստանալ այն գրված Ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել Sutter Health Plus-ի Անդամների սպասարկման բաժին՝ 1-855-315-5800 (TTY 1-855-830-3500) հեռախոսահամարով: (Armenian)

**សារ:សំខាន់៖ តើអ្នកអាចអានសេចក្តីនេះឬទេ? បើសិនមិនអាចទេ Sutter Health Plus អាចមាន
នរណាម្នាក់ជួយអានវាជូនអ្នក ។ អ្នកក៏អាចនឹងឲ្យបានសេចក្តីនេះ សរសេរជាភាសារបស់អ្នកដែរ។ សំ
រាប់ជំនួយដោយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ ផ្នែកសេវាសមាជិក Sutter Health Plus តាមលេខ
1-855-315-5800 (TTY 1-855-830-3500)។ (Cambodian)**

نکته مهم: آیا می توانید این مطالب را بخوانید و بفهمید؟ اگر نمی توانید، Sutter Health Plus می تواند از فردی کمک بگیرد تا آنرا برایتان بخواند. همچنین امکان ترجمه این مطالب به زبان فارسی وجود دارد. برای دریافت خدمات و کمک رایگان، لطفاً با دفتر خدمات اعضای Sutter Health Plus با شماره تلفن 1-855-315-5800 (TTY 1-855-830-3500) تماس بگیرید. (Farsi)

महत्वपूर्ण: क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सट्टर हेल्थ प्लस इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा में भी लिखवाने में समर्थ हो सकते/सकती हैं। निःशुल्क सहायता के लिए, कृपया 1-855-315-5800 (TTY 1-855-830-3500) पर सट्टर हेल्थ प्लस मेंबर सर्विसेस को कॉल करें। (Hindi)

LUS TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Yog koj nyeem tsis tau, Sutter Health Plus muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, peb tuaj yeem muab sau ua hom lus koj nyeem tau rau koj tib si. Yog koj xav tau kev pab pub dawb, thov hu rau Sutter Health Plus Lub Chaw Pab Cuam Tswv Cuab ntawm tus xov tooj 1-855-315-5800 (TTY 1-855-830-3500). (Hmong)

重要なお知らせ：これを読むことができますか？読めない場合は、Sutter Health Plus が読むのをお手伝いします。あなたの言語で表示できるかもしれません。無料のご相談は、Sutter Health Plus Member Services、電話: 1-855-315-5800 (TTY 1-855-830-3500) まで。(Japanese)

중요: 귀하는 이것을 읽으실 수 있습니까? 만약 읽으실 수 없다면, Sutter Health Plus 에서 다른 사람에게 부탁하여 그것을 읽으실 수 있도록 도와드릴 수 있습니다. 또한 이것을 귀하의 사용 언어로 작성해 받으실 수도 있습니다. Sutter Health Plus 회원 서비스(1-855-315-5800 (TTY 1-855-830-3500))에 전화를 하시어 무상으로 도움을 받으십시오. (Korean)

ໝາຍເຫດ: ທ່ານອ່ານໄດ້ຈົດໝາຍສະບັບນີ້ບໍ່? ຖ້າອ່ານບໍ່ໄດ້, ທາງ Sutter Health Plus ມີ ພະນັກງານຊ່ວຍອ່ານໃຫ້ທ່ານ. ນອກຈາກນັ້ນ, ພວກເຮົາຍັງສາມາດຂຽນເປັນພາສາຂອງທ່ານໃຫ້ທ່ານອີກ ດ້ວຍ. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໂດຍບໍ່ເສຍຄ່າບໍລິການ, ກະລຸນາຕິດຕໍ່ ໜ່ວຍບໍລິການ ຂອງ Sutter Health Plus ທີ່ໝາຍເລກໂທລະສັບ 1-855-315-5800 (TTY 1-855-830-3500). (Laotian)

ਅਹਿਮ: ਕੀ ਤੁਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ, Sutter Health Plus (ਸੱਟਰ ਹੈਲਥ ਪਲਸ) ਕਿਸੇ ਤੋਂ ਇਹ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮੱਦਦ ਕਰਵਾ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮੱਦਦ ਲਈ ਕਿਰਪਾ ਕਰ ਕੇ Sutter Health Plus Member Services ਨੂੰ 1-855-315-5800 (TTY 1-855-830-3500) ਉੱਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ВАЖНО: Вы можете это прочитать? Если нет, Sutter Health Plus может предоставить Вам кого-то, кто сможет помочь Вам прочитать это. Вы также можете получить это в письменной форме на своем языке. Для бесплатной помощи позвоните в Службу поддержки членов Sutter Health Plus по телефону 1-855-315-5800 (TTY 1-855-830-3500). (Russian)

MAHALAGA: Nababasa mo ba ito? Kung hindi, maaari kang bigyan ng Sutter Health Plus ng taong babasa para sa iyo. Maaari mo ding hilingin na isulat ito sa iyong wika. Para sa walang-gastos na tulong, mangyaring tumawag sa Sutter Health Plus Member Services sa. 1-855-315-5800 (TTY 1-855-830-3500). (Tagalog)

สำคัญ: คุณอ่านออกหรือไม่ ถ้าอ่านไม่ออก Sutter Health Plus สามารถให้คนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถขอรับเนื้อหานี้เป็นภาษาของคุณได้อีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย กรุณาโทรหา Sutter Health Plus Member Services ที่ 1-855-315-5800 (TTY 1-855-830-3500) (Thai)

QUAN TRỌNG: Qu. vị có thể đọc thông tin này không? Nếu không, Sutter Health Plus có thể yêu cầu ai đó đọc giúp cho qu. vị. Qu. vị cũng có thể nhận được thông tin này dưới dạng văn bản bằng ngôn ngữ của qu. vị. Để được hỗ trợ miễn phí, vui lòng gọi cho ban Dịch Vụ Thành Viên của Sutter Health Plus theo số 1-855-315-5800 (TTY 1-855-830-3500). (Vietnamese)