### Summary of Benefits and Coverage

**What this Plan Covers & What You Pay for Covered Services**

**Sutter Health Plus: Peak ML60 HMO**

**Coverage Period:** Beginning on or after 01/01/2022

**Coverage for:** Large Group | **Plan Type:** HMO

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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

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<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
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<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$5,500 individual / $5,500 individual family member / $11,000 family for certain medical services per calendar year.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care and other services as indicated in the chart starting on page 2 are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment (copay) 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$6,500 individual / $6,500 individual family member / $13,000 family per calendar year.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, health care this plan doesn’t cover and cost sharing for most optional benefits if elected by your employer group.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
</tbody>
</table>
**Will you pay less if you use a network provider?**

Yes. See [www.sutterhealthplus.org/provider-search](http://www.sutterhealthplus.org/provider-search) or call 1-855-315-5800 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?**

Yes.

This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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**Common Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions & Other Important Information**
--- | --- | --- | ---
**If you visit a health care provider’s office or clinic**

**Primary Care Physician (PCP) Visit to treat an injury or illness**

PCP Office Visit: $50 copay per visit
Sutter Walk-in Care Visit: $20 copay per visit
Telehealth Visit: $20 copay per visit
Deductible does not apply

**Specialist Visit**

Specialist Office Visit: $50 copay per visit
Telehealth Visit: $20 copay per visit
Deductible does not apply

**Preventive Care / Screening / Immunization**

No charge
Deductible does not apply

**If you have a test**

**Diagnostic Test (X-ray, blood work)**

Lab: $10 copay per visit
X-ray: $50 copay per procedure
Deductible does not apply

**Imaging (CT/PET scans, MRIs)**

$100 copay per procedure

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

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at [www.sutterhealthplus.org/about/plans-benefits](http://www.sutterhealthplus.org/about/plans-benefits) or call 1-855-315-5800.
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<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 (Most generic drugs and low-cost preferred brand name drugs)</td>
<td>Participating Provider: Retail: $10 copay per prescription&lt;br&gt;Mail Order: $20 copay per prescription&lt;br&gt;Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Preferred brand name drugs and non-preferred generic drugs)</td>
<td>Participating Provider: Retail: $30 copay per prescription&lt;br&gt;Mail Order: $60 copay per prescription&lt;br&gt;Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Non-preferred brand name drugs)</td>
<td>Participating Provider: Retail: $60 copay per prescription&lt;br&gt;Mail Order: $120 copay per prescription&lt;br&gt;Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 4 (Specialty drugs)</td>
<td>Specialty Pharmacy: 30% coinsurance up to $250 per prescription&lt;br&gt;Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility Fee (e.g., ambulatory surgery center)</td>
<td>30% coinsurance</td>
<td>Prior authorization is required. If it is not received, you may be responsible for paying all charges.</td>
</tr>
<tr>
<td></td>
<td>Physician / Surgeon Fee</td>
<td>30% coinsurance</td>
<td></td>
</tr>
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<td>---------------------------------------------</td>
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<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency Room Care</td>
<td>Facility: $150 copay per visit Professional: No charge</td>
<td>If admitted to the hospital, Emergency Room Care cost sharing will not apply. See hospital stay information below for applicable cost sharing.</td>
</tr>
<tr>
<td></td>
<td>Emergency Medical Transportation</td>
<td>$150 copay per trip</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Urgent Care</td>
<td>$50 copay per visit Deductible does not apply</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility Fee (e.g., hospital room)</td>
<td>30% coinsurance</td>
<td>Prior authorization is required. If it is not received, you may be responsible for paying all charges.</td>
</tr>
<tr>
<td></td>
<td>Physician / Surgeon Fees</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance use disorder (MH/SUD) services</td>
<td>Outpatient Services</td>
<td>Individual Office Visit: $50 copay per visit; deductible does not apply Group Office Visit: $25 copay per visit; deductible does not apply Telehealth Office Visit: $20 copay per visit; deductible does not apply Other Outpatient Services: 30% coinsurance</td>
<td>You may self-refer to a USBHPC provider 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.</td>
</tr>
<tr>
<td></td>
<td>Inpatient Services</td>
<td>Facility: 30% coinsurance Professional: 30% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
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<td>If you are pregnant</td>
<td></td>
<td></td>
<td>Prenatal and Postnatal Care includes all prenatal office visits and the first postnatal office visit. Refer to the PCP Visit cost sharing for all subsequent postnatal office visits. Maternity care may include tests and services described elsewhere in the SBC (e.g., Diagnostic Tests such as ultrasounds and blood work).</td>
</tr>
<tr>
<td></td>
<td>Office Visits</td>
<td>Participating Provider: No charge Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Participating Provider: Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth / Delivery Professional Services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth / Delivery Facility Services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home Health Care</td>
<td>No charge Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation Services</td>
<td>$50 copay per visit Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation Services</td>
<td>$50 copay per visit Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing Care</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable Medical Equipment</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice Services</td>
<td>No charge Deductible does not apply</td>
<td>Not covered</td>
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<td></td>
<td></td>
<td>Participating Provider</td>
<td>Non-Participating Provider</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s Eye Exam</td>
<td>No charge</td>
<td>Up to $45 max reimbursement</td>
</tr>
<tr>
<td>For more information, contact Vision Services Plan (VSP) at 1-800-877-7195.</td>
<td>Children’s Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s Dental Check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**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.)

- Chiropractic care
- Commercial weight loss programs
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

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

- 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
- Routine eye care (Adult) limited to an annual preventive eye exam through VSP; embedded in medical plan.
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? 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.

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.
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.

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<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network prenatal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow-up care)</td>
</tr>
<tr>
<td>■ The plan’s overall deductible $5,500</td>
<td>■ The plan’s overall deductible $5,500</td>
<td>■ The plan’s overall deductible $5,500</td>
</tr>
<tr>
<td>■ Specialist copayment $50</td>
<td>■ Specialist copayment $50</td>
<td>■ Specialist copayment $50</td>
</tr>
<tr>
<td>■ Hospital (facility) coinsurance 30%</td>
<td>■ Hospital (facility) coinsurance 30%</td>
<td>■ Hospital (facility) coinsurance 30%</td>
</tr>
<tr>
<td>■ Other coinsurance 30%</td>
<td>■ Other coinsurance 30%</td>
<td>■ Other coinsurance 30%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:

Peg is Having a Baby:
- Office Visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services (anesthesia)
- Diagnostic Tests (ultrasounds and blood work)

Managing Joe’s Type 2 Diabetes:
- Primary Care Physician Office Visits (including disease education)
- Diagnostic Tests (blood work)
- Prescription Drugs (including glucose meter)

Mia’s Simple Fracture:
- Emergency Room Care (including medical supplies)
- Diagnostic Tests (X-ray)
- Durable Medical Equipment (crutches)
- Rehabilitation Services (physical therapy)

Total Example Cost $12,700
In this example, Peg would pay:
- Cost Sharing
  - Deductible(s) $5,500
  - Copayments $50
  - Coinsurance $900
- What isn’t covered
  - Limits or excluded services $60
- The total Peg would pay is $6,510

Total Example Cost $5,600
In this example, Joe would pay:
- Cost Sharing
  - Deductible(s) $0
  - Copayments $1,300
  - Coinsurance $0
- What isn’t covered
  - Limits or excluded services $20
- The total Joe would pay is $1,320

Total Example Cost $2,800
In this example, Mia would pay:
- Cost Sharing
  - Deductible(s) $1,900
  - Copayments $400
  - Coinsurance $0
- What isn’t covered
  - Limits or excluded services $20
- The total Mia would pay is $2,300

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 تكون قادرًا فاعمل أن صنر هيلث بلاس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنه مساعدتك في قراءة هذا النص. كما يمكنك أيضًا أن تتلقى مكتوبًا بنغلكه. للحصول على مساعدة مجانية، يرجى الاتصال بخدمات أعضاء صَتر هیلث بلاس (Sutter Health Plus Member Services) على هاتف 1-855-315-5800 (TTY 1-855-830-3500) . (Arabic)

ԿԱՐԵՎՈՐՏԵՂԵԿԱՏՎՈՒԹՅՈՒՆ. Կարո՞ղ եք կարդել սա? եթե չեք, 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 կոչեք 1-855-315-5800 (TTY 1-855-830-3500) հեռախոսահամար։ (Armenian)

សារៈសំខាន់៖ ត ើអ្នកអាចអានតនេះឬតេ? ត ើសិនមិនអាចតេ Sutter Health Plus អាចមាននរណាមា នក់ជួយអានវាជូនអ្នក ។ អ្នកក៏អាចនឹងឲ្យបានតនេះ សរតសរជាភាសារ ស់អ្នកដែរ។ សំ រា ់ជំនួយតោយឥ អ្ស់ថ្លៃ សូមេូរស័ព្ទតៅ ដននកតសវាសមាជិក Sutter Health Plus តាមតេខ 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 که بتواند این مطالب را به زبان فارسی درک کند و به شما تلفن (3500) 1-855-315-5800 تکلیف دهد. (Farsi)

महत्वपूर्ण: क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सदर 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। निश्चित रूप से सहायता के लिए, कृपया 1-855-315-5800 (TTY 1-855-830-3500) पर सदर हेल्थ प्लस मेंबर सर्विसस को कॉल करें। (Hindi)

(Mongolian)

南語訳: 您能閱讀這段嗎？如果不能，Sutter Health Plus可以找人替您朗讀。您也可以以自己的語言獲得這段的书面形式。Sutter Health Plus成員服務 (1-855-315-5800 (TTY 1-855-830-3500)) 電話為您提供無費服務。 (Japanese)


 महासेवा: तपाईंले यो लेख अनुसन्धान गर्न सक्दै? यदि नभएको तर, सुटर हेल्थ प्लस (मेम्बर सर्विस) मा मार्फत तपाईंले यो लेख पढाउदै सक्दै। तपाईंले यो लेख उपभोक्ता भाषामा ले पढाउदै सक्दै। तपाईंले सुटर हेल्थ प्लस मेम्बर सर्विस (1-855-315-5800 (TTY 1-855-830-3500))मा दुई हफ्ताको केही समयले यो लेख पढाउदै सक्दै। (Laotian)

 ਮਹਾਸੇਵਾ: ਇਸ ਲਖ ਦੁਆਰਾ ਪ੍ਰਧਾਨ ਕਖਾ ਨਾਲ ਦੇਣ ਦੇ ਸਕਦੇ ਹਨ? ਨਹੀਂ ਹਾਂ ਤਾਂ, Sutter Health Plus ਨਾਲ ਮੇਮਬਰ ਸਰਵਿਸ ਦੁਆਰਾ ਇਸ ਲਖ ਦੁਆਰਾ ਪ੍ਰਧਾਨ ਕਖਾ ਨਾਲ ਦੇਣ ਦੇ ਸਕਦੇ ਹਨ। ਇਸ ਲਖ ਦੁਆਰਾ ਸੰਗਰਹ ਸੰਬੰਧੀ ਕਖਾ ਨਾਲ ਦੇਣ ਦੇ ਸਕਦੇ ਹਨ। ਸੁਟਰ ਹੇਲਥ ਪਲਸ ਮੇਮਬਰ ਸਰਵਿਸ (1-855-315-5800 (TTY 1-855-830-3500)) ਦੁਆਰਾ ਇਸ ਲਖ ਦੁਆਰਾ ਪ੍ਰਧਾਨ ਕਖਾ ਨਾਲ ਦੇਣ ਦੇ ਸਕਦੇ ਹਨ। (Punjabi)

 БАЖКО: 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)


สิ่งสำคัญ: คุณเข้าใจหรือไม่ ถ้าคุณไม่เข้าใจ Sutter Health Plus สามารถให้คุณ有助于ตัวเองได้ นอกจากนี้ คุณยังสามารถร้องขอตรวจสอบได้เป็นการให้คุณได้รับข้อมูลที่จำเป็นต่อการตัดสินใจของคุณด้วย โดยไม่มีค่าใช้จ่าย กรุณาโทรศัพท์ Sutter Health Plus Member Services ที่ 1-855-315-5800 (TTY 1-855-830-3500) (Thai)

QUAN TRỌNG: Qu. v.i có thể đọc thông tin này không? Nếu không, Sutter Health Plus có thể yêu cầu ai đó đọc giúp cho qu. v.i. Qu. v.i cũng có thể nhận được thông tin này được đăng trên các bảng ngôn ngữ của qu. v.i. 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)