Ambetter Balanced Care 4 (2017)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 01/01/2017
Coverage for: All Covered Members | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ambetterhealthnet.com or by calling 1-888-926-5057.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,000 member / $4,000 family per calendar year. Does not apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $2,000 member / $4,000 family per calendar year. Deductible included in out-of-pocket limit.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.ambetterhealthnet.com or call 1-888-926-5057.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call the number on your Ambetter from Health Net ID card (current members) or 1-888-926-5057 or visit us at www.ambetterhealthnet.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov or call 1-888-926-5057 or the number on your Ambetter from Health Net ID card to request a copy.

Note: The coverage period shown above for this plan may be different than the effective date of your particular policy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge deductible waived	Not covered	——————none——————
	Specialist visit	$5/visit deductible waived	Not covered	——————none——————
	Other practitioner office visit	Other practitioner-No charge deductible waived; Chiropractic-$5/visit deductible waived; Acupuncture-Not covered	Not covered	Chiropractic-Limited to 20 visits per calendar year. Acupuncture-Not covered
	Preventive care/screening/immunization	No charge deductible waived	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance deductible applies	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	0% coinsurance deductible applies	Not covered	Requires prior authorization.
If you need drugs to treat your illness or condition	Generic drugs	No charge/retail order deductible waived No charge/mail order deductible waived	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.ambetterhealthnet.com	Preferred brand drugs or preferred insulin	$25/retail order deductible waived; $75/mail order deductible waived	Not covered	Supply/order: 30 day (retail); 30-90 day (mail order), If you select a brand name drug that has a generic equivalent, your cost will be higher, May require prior authorization.
	Non-preferred brand drugs	$0/retail order deductible applies; $0/mail order deductible applies	Not covered	
	Anti-cancer drugs	0% coinsurance/order deductible applies	Not covered	
	Specialty drugs	0% coinsurance/order deductible applies	Not covered	Supply/order: 30 day supply filled by a specialty pharmacy. May require prior authorization
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance deductible applies	Not covered	Requires prior authorization.
	Physician/surgeon fees	0% coinsurance deductible applies	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	0% coinsurance deductible applies	0% coinsurance deductible applies	——————none——————
	Emergency medical transportation	0% coinsurance deductible applies	0% coinsurance deductible applies	——————none——————
	Urgent care	$50/visit deductible waived	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance deductible applies	Not covered	Requires prior authorization.
	Physician/surgeon fee	0% coinsurance deductible applies	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office-No charge deductible waived; Other than office-0% coinsurance deductible applies	Not covered	Office-May require prior authorization. Other than office- Requires prior authorization.
	Mental/Behavioral health inpatient services	0% coinsurance deductible applies	Not covered	Requires prior authorization.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Substance abuse disorder outpatient services	Office-No charge deductible waived; Other than office-0% coinsurance deductible applies	Not covered	Requires prior authorization.
	Substance abuse disorder inpatient services	0% coinsurance deductible applies	Not covered	Requires prior authorization.
If you are pregnant	Prenatal and postnatal care	No charge deductible waived	Not covered	————————none————————
	Delivery and all inpatient services	0% coinsurance deductible applies	Not covered	Requires prior authorization.
If you need help recovering or have other special health needs	Home health care	0% coinsurance deductible applies	Not covered	Limited to part-time and intermittent nursing care. Requires prior authorization.
	Rehabilitation services	0% coinsurance deductible applies	Not covered	Outpatient-Limited to 60 visits per calendar year (all therapies combined). Requires prior authorization.
	Habilitation services	0% coinsurance deductible applies	Not covered	Outpatient-Limited to 60 visits per calendar year (all therapies combined). Requires prior authorization.
	Skilled nursing care	0% coinsurance deductible applies	Not covered	Limited to 100 days per calendar year. Requires prior authorization.
	Durable medical equipment	0% coinsurance deductible applies	Not covered	Requires prior authorization.
	Hospice service	0% coinsurance deductible applies	Not covered	Requires prior authorization.
If your child needs dental or eye care	Eye exam	No charge deductible waived	Not covered	Eye exams are limited to 1 visit per year.
	Glasses	No charge deductible waived	Not covered	Glasses are limited to 1 pair per year. Ambetter from Health Net vision benefits are provided through Eyemed.
	Dental check-up	Not covered	Not covered	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Abortion services (except in cases of rape, incest or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing except when medically necessary
- Weight loss program

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Routine eye care (Adult)
- Routine foot care (Covered only in connection with the treatment of diabetes)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep health this coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit Fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the plan at 1-888-926-5057. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Ambetter from Health Net Customer Contact Center at 1-888-926-5057, submit a grievance form through www.ambetterhealthnet.com, or file your complaint in writing to, Commercial Appeals and Grievances Department, Attn: Appeals & Grievances Manager, Ambetter from Health Net, P.O. Box 277610, Sacramento, CA 95827. You may also call the Consumer Services Division of the Arizona Department of Insurance at 602-364-2499 or 1-800-325-2548 (outside the Metro Phoenix area).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-800-223-7691.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-223-7691.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-223-7691.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-223-7691.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,340
- **Patient pays** $2,200

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$2,200**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,320
- **Patient pays** $2,080

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,080**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Health Net of Arizona, Inc. and Health Net Life Insurance Company (“Health Net”) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).

• Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:
Arizona Marketplace Individual/Family Plans 1-888-926-5057 (TTY: 711)
Arizona Marketplace Small Group Plans 1-888-926-5122 (TTY: 711)
Non-Marketplace/Off Exchange Plans 1-800-289-2818 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800–537–7697).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card. Individual & Family Plan members please call 1-888-926-5057 (TTY: 711); Small Business members please call 1-888-926-5122 (TTY: 711). Employer group members please call 1-800-289-2818 (TTY: 711).

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية. يرجى من أعضاء خطة الأفراد والعائلة الاتصال على الرقم 1-888-926-5057 (TTY: 711)؛ ويرجى من أعضاء الأعمال الصغيرة الاتصال على الرقم 1-888-926-5122 (TTY: 711). يرجى من أعضاء مجموعة أصحاب العمل الاتصال على الرقم 1-800-289-2818 (TTY: 711).

Chinese
免費語言服務。您可使用口譯員。您可請人將文件內容唸給您聽。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡。個人與家庭計畫的會員請致電 1-888-926-5057 (TTY: 711) 小型企業的會員請致電 1-888-926-5122 (TTY: 711) 。雇主團體的會員請致電 1-800-289-2818 (TTY: 711) 。

French
Aucun service linguistique avec coût. Vous pouvez obtenir un interprète. Les documents peuvent être lus pour vous. Pour obtenir de l'aide, appelez-nous au numéro figurant sur votre carte d'identité. Membres des programmes pour particuliers et familles, veuillez composer le 1-888-926-5057 (TTY: 711). Membres des programmes pour petites entreprises, veuillez composer le 1-888-926-5122 (TTY: 711). Membres du groupe d'employeurs, veuillez composer le 1-800-289-2818 (TTY: 711).

German
Kostenloser Sprachendienst. Dolmetscher sind verfügbar. Dokumente können Ihnen vorgelesen werden. Wenn Sie Hilfe benötigen, rufen Sie uns unter der Nummer auf Ihrer ID-Karte an. Mitglieder von Einzel- und Familienpolicen rufen bitte unter 1-888-926-5057 (TTY: 711) an; Kleinunternehmen-Mitglieder rufen bitte unter 1-888-926-5122 (TTY: 711) an. Arbeitgeber-Gruppenmitglieder rufen bitte unter 1-800-289-2818 (TTY: 711) an.

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話ください。個人および家族向けプランのメンバーの方は1-888-926-5057（TTY：711）まで、小規模企業メンバーの方は1-888-926-5122（TTY：711）までお電話ください。雇用主を通じた団体保険のメンバーの方は、1-800-289-2818（TTY：711）までお電話ください。

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스를 받으실 수 있습니다. 도움을 원하시면, 보험 ID에 수록된 번호로 전화해 주십시오. 개인 및 가족 계획가입자분은 1-888-926-5057 (TTY: 711)번으로 전화해 주시고, 소기업가입자분은 1-888-926-5122 (TTY: 711)번으로 전화해 주십시오. 고용주 그룹 가입자분은 1-800-289-2818 (TTY: 711)번으로 전화해 주십시오.

Navajo

Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hóló̜. T'áá hó hazaad k'ehjí naaltsoos hach'į' wóltah dóó ła' da hach'į' él'įįh.Shíká a'doowoł nínízingo naaltsoos bee néího'dólzinígíí bikáa'gi béésh bee hane'í bikáá' áajį' hodíílnih. T'áá hó dóó ha'áłchíní bił hak'é'ésti'ígíí kojį' hojilnih 1-888-926-5057 (TTY: 711); Small business deiłnínííjí atah nílį́įgo éí kojį' hólne' 1-888-926-5122 (TTY: 711). Employer groupo̜jí atah nílį́įgo éí kojį' hodíílnih 1-800-289-2818 (TTY: 711).

Persian (Farsi)

کسب اطلاعات، با ما به شماره ای که در کارت شناسایی شما قید شده تماس بگیرید. اعضای برنامه انفرادی و خانواده لطفاً با شماره 1-888-926-5057 (TTY: 711) تماس بگیرید؛ اعضای واحد بازرگانی کوچک با شماره 1-888-926-5122 (TTY: 711) تماس بگیرید. اعضای گروه کارفرما لطفاً با شماره 1-800-289-2818 (TTY: 711) تماس بگیرید.

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Участники планов для семей и частных лиц: звоните по телефону 1-888-926-5057 (TTY: 711). Участники планов для малых предприятий: звоните по телефону 1-888-926-5122 (TTY: 711). Участники групповых планов, предоставляемых работодателем: звоните по телефону 1-800-289-2818 (TTY: 711).

Serbo-Croatian

Besplatne jezičke usluge. Možemo vam obezbediti tumača. Možemo vam pročitati vaše dokumente. Ukoliko vam je potrebna pomoć, nazovite broj napisan na vašoj zdravstvenoj kartici. Molimo članove individualnog i porodičnog plana da nazovu 1-888-926-5057 (TTY: 711); molimo članove malog preduzeća da nazovu 1-888-926-5122 (TTY: 711). Molimo članove grupe osigurane preko poslodavca da nazovu 1-800-289-2818 (TTY: 711).

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación. Los afiliados de planes individuales y familiares deben llamar al 1-888-926-5057 (TTY: 711); los afiliados de pequeñas empresas deben llamar al 1-888-926-5122 (TTY: 711). Los afiliados del grupo del empleador deben llamar al 1-800-289-2818 (TTY: 711).

Syriac (Assyrian)

ܡܬܚܡܬܐ ܠܫܢܢܝܐ ܡܓܢ (ܕܠܐ ܦܘܪܥܢܐ). ܡܨܝܬ ܕܡܫܟܚܬܘܢ ܚܕ ܬܪܓܡܢܐ. ܡܨܝܬ ܕܡܩܪܝܬ ܐܠܟܘܢ ܣܦܪܐ ܕܝܠܟܘܢ. ܩܐ ܥܘܕܪܢܐ، ܩܪܘ ܠܢ ܥܠ ܡܢܝܢܐ ܕܟܬܝܒܐ ܥܠ ܦܬܩܐ ܕܡܬܝܕܥܘܬܘܢ. ܦܪܝ ܦܠܐ ܢ ܡܢܝܢܐ ܕܡܫܦܚܬܐ ܝܢ ܗܘܡܐ ܠܗܘܢ ܩܪܝܢ ܥܠ ܡܢܝܢܐ 1-888-926-5057 (TTY: 711)؛ ܗܕܡܐ ܕܬܓܪܘܬܐ ܙܥܘܪܬܐ ܝܢ ܗܘܡܐ ܠܗܘܢ ܩܪܝܢ ܥܠ 1-888-926-5122 (TTY: 711). ܗܕܡܐ ܕܓܘܫܐ ܕܡܦܠܚܢܐ ܕܦܠܚܐ ܝܢ ܗܘܡܐ ܠܗܘܢ ܩܪܝܢ ܥܠ ܡܢܝܢܐ 1-800-289-2818 (TTY: 711).

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card. Para sa mga miyembro ng Plano para sa Indibiduwal at Pamilya mangyaring tawagan ang 1-888-926-5057 (TTY: 711); Para sa mga miyembro na Maliit na Negosyo, mangyaring tawagan ang 1-888-926-5122 (TTY: 711). Para sa mga miyembro ng grupo ng empleyado, mangyaring tawagan ang 1-800-289-2818 (TTY: 711).

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ สมาชิกแผนบุคคลและครอบครัว กรุณาโทร 1-888-926-5057 (TTY: 711); สมาชิกธุรกิจขนาดเล็ก กรุณาโทร 1-888-926-5122 (TTY: 711) สมาชิกกลุ่มนายจ้าง กรุณาโทร 1-800-289-2818 (TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c`âu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị. Các thành viên của Chương Trình Cá Nhân & Gia Đình vui lòng gọi số 1-888-926-5057 (TTY: 711); Các thành viên thuộc Doanh Nghiệp Nhỏ vui lòng gọi số 1-888-926-5122 (TTY: 711). Các thành viên thuộc chương trình theo nhóm của chủ sử dụng lao động vui lòng gọi số 1-800-289-2818 (TTY: 711).

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