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, visit www.healthnet.com/portal/shopping/content/iwc/shopping/contact_us.action or call 1-800-289-2818. 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 www.dol.gov/ebsa/healthreform or www.healthnet.com or you can call 1-800-289-2818 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For preferred providers $5,500 member / $11,000 family. For out-of-network providers $10,000 member / $20,000 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Primary care/specialist visits, preventive care, prescription drugs, urgent care, outpatient office mental health/substance abuse visits, prenatal/postnatal office visits and pediatric vision are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	Yes. $100 pediatric dental deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For preferred providers $7,350 member / $14,700 family. For out-of-network providers $15,000 member / $30,000 family per calendar year. Deductible included in out-of-pocket limit.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.healthnet.com or call 1-800-289-2818 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45/visit deductible does not apply	50% coinsurance	——————none——————
	Specialist visit	$90/visit deductible does not apply	50% coinsurance	——————none——————
	Preventive care/screening/ immunization	No charge deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	If precertification is not obtained benefit is reduced by 50% in-network and not covered out-of-network.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthnet.com	Generic drugs	$20/retail order; $60/mail order	100% at point of sale*	Supply/order: 30 day (retail); 30-90 day (mail order). Member may be responsible for cost difference between the brand and generic drug plus generic copay if a brand is dispensed when a generic is available. May require precertification. *Subject to reimbursement of an allowed amount less 50% coinsurance upon your submission of a claim.
	Preferred brand drugs or preferred insulin	$70/retail order; $210/mail order	100% at point of sale*	
	Non-preferred brand drugs	$120/retail order; $360/mail order	100% at point of sale*	
	Anti-cancer drugs	20% coinsurance/order	100% at point of sale*	
	Specialty drugs	50% coinsurance/order	Not covered	Supply/order: 30 day supply filled by a specialty pharmacy. May require precertification.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital-30% coinsurance; ASC-20% coinsurance	50% coinsurance	If precertification is not obtained benefit is reduced by 50% in-network and not covered out-of-network.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	——————none——————
If you need immediate	Emergency room care	30% coinsurance	30% coinsurance	——————none——————

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
medical attention	Emergency medical transportation	30% coinsurance	30% coinsurance	——————none——————
	Urgent care	$50/visit deductible does not apply	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	If precertification is not obtained benefit is reduced by 50% in-network and not covered out-of-network.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office-$45/visit deductible does not apply; Other than office-30% coinsurance	50% coinsurance	If precertification is not obtained benefit is reduced by 50% in-network and not covered out-of-network.
	Inpatient services	30% coinsurance	50% coinsurance	If precertification is not obtained benefit is reduced by 50% in-network and not covered out-of-network.
If you are pregnant	Office visits	PCP-$45/visit deductible does not apply; Specialist-$90/visit deductible does not apply	50% coinsurance	——————none——————
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	If precertification is not obtained benefit is reduced by 50% in-network and not covered out-of-network.
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to part-time and intermittent nursing care. If precertification is not obtained benefit is reduced by 50% in-network and not covered out-of-network.
	Rehabilitation services	Inpatient/Outpatient-30% coinsurance	50% coinsurance	Outpatient-Limited to 60 visits per calendar year, in-network/out-of-network combined (all therapy services combined). If precertification is not obtained benefit is reduced by 50% in-network and not covered out-of-network.

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	Inpatient/Outpatient- 30% coinsurance	50% coinsurance	Outpatient-Limited to 60 visits per calendar year (in-network/out-of-network combined). If precertification is not obtained benefit is reduced by 50% in-network and not covered out-of-network.
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 100 days per calendar year (in-network/out-of-network combined). If precertification is not obtained benefit is reduced by 50% in-network and not covered out-of-network.
	Durable medical equipment	30% coinsurance	50% coinsurance	If precertification is not obtained benefit is reduced by 50% in-network and not covered out-of-network.
	Hospice services	30% coinsurance	50% coinsurance	If precertification is not obtained benefit is reduced by 50% in-network and not covered out-of-network.
If your child needs dental or eye care	Children's eye exam	No charge deductible does not apply	75% of retail	Limited to 1 visit per year.
	Children's glasses	No charge deductible does not apply	75% of retail	Provider selected frames; 1 per calendar year.
	Children's dental check-up	No charge after deductible is met	No charge after deductible is met	Diagnostic and preventive only. $100 deductible required (applied to all services).

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.)

- 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 outside the U.S.
- Private-duty nursing except when medically necessary
- Routine eye care (Adult)
- Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care	• Hearing aids	• Routine foot care (Covered only in connection with the treatment of diabetes)

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. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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 the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Health Net's Customer Contact Center at 1-800-522-0088, submit a grievance form through www.healthnet.com, or file your complaint in writing to, Health Net Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348. For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444 (EBSA (3272) or www.dol.gov/ebsa/healthreform. If you have a grievance against Health Net, you can also contact the Commercial Appeals and Grievances Department, Attn: Appeals & Grievances Manager, Health Net of Arizona, 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 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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, 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 section.

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com.

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	**$5,500**
Specialist copayment	**$90**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,600
Copayments	$0
Coinsurance	$3,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,360**

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

The plan's overall deductible	**$5,500**
Specialist copayment	**$90**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$2,100
Coinsurance	$600
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4,055**

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

The plan's overall deductible	**$5,500**
Specialist copayment	**$90**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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

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: Individual/Family Plans 1-888-926-5057 (TTY: 711)
Arizona Marketplace Small Group Plans 1-888-926-5122 (TTY: 711)
Small Business Group plans and Large Employer Group 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).

Navajo

Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hóló. 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'ałchíní bił hak'é'ésti'ígíí kojį' hojilnih 1-888-926-5057 (TTY: 711); Small business deiłníníjí atah nílįįgo éí kojį' hólne' 1-888-926-5122 (TTY: 711). Employer groupǫjí atah nílįįgo 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).

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.

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)
ܫܘܬܦܐ ܕܠܫܢܐ ܠܐ ܥܠ ܚܠܦ ܡܬܚܝܒ ܐܢ ܬܫܬܡܫ ܒܬܘܪܓܡܢܐ. ܡܬܚܝܒ ܐܢ ܢܬܪܓܡ ܠܟ ܡܫܡܟ. ܐܢ ܡܬܚܝܒ ܐܢ ܬܩܪܐ ܠܢ ܡܫܡܟ ܐܢ ܐܝܬ ܠܟ ܫܐܠܬܐ ܐܘ ܒܥܝܬ ܥܕܪܐ ܐܬܨܠ ܒܢ ܠܡܣܦܪ ܕܟܬܝܒ ܥܠ ܟܪܛܝܣ ܕܗܘܝܬܟ. ܠܠܝܩܪ ܡܫܬܡܫܝ ܚܫܒܘܢ ܕܬܬܨܠ ܒܢ ܠ 1-888-926-5057 (TTY: 711); ܠܠܝܩܪ ܡܫܬܡܫܝ ܥܣܩܐ ܙܥܘܪܐ ܕܬܬܨܠ ܒܢ ܠ 1-888-926-5122 (TTY: 711). ܠܠܝܩܪ ܡܫܬܡܫܝ ܟܘܪܣ ܕܡܬܟܣܝ ܥܠ ܝܕ ܡܫܘܚܪܐ ܕܬܬܨܠ ܒܢ ܠ 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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