



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, call the number on your Health Net ID card (current members) or 1-888-802-7001 or visit us at [www.healthnet.com](http://www.healthnet.com). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.dol.gov/ebsa/healthreform> or [www.healthnet.com](http://www.healthnet.com) or you can call 1-888-802-7001 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$1,500 member/\$3,000 family per calendar year (all levels combined).	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , primary care visits, <a href="#">specialist</a> visits, <a href="#">diagnostic tests</a> , <a href="#">prescription drugs</a> , <a href="#">emergency room care</a> , <a href="#">urgent care</a> and outpatient mental health/substance abuse office visits are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<u>Medical limit</u> : \$4,500 member/\$9,000 family per calendar year (all levels combined). <u>Separate pharmacy limit</u> : \$2,000 member/\$4,000 family per calendar year. <a href="#">Deductible</a> included in OOPL.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, and healthcare this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.healthnet.com">www.healthnet.com</a> or call 1-888-802-7001 for a list of <a href="#">network providers</a> .	You will pay the least if you use a <a href="#">provider</a> in the CommunityCare <a href="#">network</a> . You pay more if you use Other Participating <a href="#">Providers</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		CommunityCare Provider (Level 1) (You will pay the least)	Other Participating Provider (Level 2) (You will pay more)	Out-of-Network Provider (Level 3) (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$10/visit deductible does not apply	40% coinsurance	40% coinsurance	_____none_____
	<a href="#">Specialist</a> visit	\$50/visit deductible does not apply	40% coinsurance	40% coinsurance	_____none_____
	<a href="#">Preventive care/screening/immunization</a>	No charge for covered services; deductible does not apply	No charge for covered services; deductible does not apply	40% 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	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance deductible does not apply	40% coinsurance deductible does not apply	40% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	40% coinsurance	Requires prior authorization.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.healthnet.com">www.healthnet.com</a> .	Tier I (Generic drugs)	\$15/retail order \$30/mail order deductible does not apply	\$15/retail order \$30/mail order deductible does not apply	Not covered	Supply/order: is for 30 day (retail); 60 and 90 day supplies available for additional charge. Mail order is for 35-90 days. May require prior authorization. Anti-cancer drugs at 20% coinsurance, deductible does not apply. Separate pharmacy limit: \$2,000 member/\$4,000 family per calendar year.
	Tier II (Preferred brand)	30% coinsurance retail/mail order deductible does not apply	30% coinsurance retail/mail order deductible does not apply	Not covered	
	Tier III (Non-preferred brand drugs)	50% coinsurance retail/mail order deductible does not apply	50% coinsurance retail/mail order deductible does not apply	Not covered	
	<a href="#">Specialty drugs</a>	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		CommunityCare Provider (Level 1) (You will pay the least)	Other Participating Provider (Level 2) (You will pay more)	Out-of-Network Provider (Level 3) (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital- 20% coinsurance ASC- 15% coinsurance	Hospital- 40% coinsurance ASC- 35% coinsurance	40% coinsurance	Requires prior authorization. Coverage includes abortion services.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	40% coinsurance	—————none—————
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250+20% coinsurance deductible does not apply	\$250+20% coinsurance deductible does not apply	\$250+20% coinsurance deductible does not apply	Copay waived if admitted as inpatient.
	<a href="#">Emergency medical transportation</a>	20% coinsurance	20% coinsurance	20% coinsurance	Ground ambulance limited to 3 trips and air ambulance limited to 1 trip per calendar year (all levels combined).
	<a href="#">Urgent care</a>	\$50/visit deductible does not apply	\$50/visit deductible does not apply	\$50/visit deductible does not apply	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	40% coinsurance	Requires prior authorization.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	40% coinsurance	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office-\$10/visit deductible does not apply Other than office- 20% coinsurance	Not covered	40% coinsurance	Requires prior authorization except for office visits.
	Inpatient services	20% coinsurance	Not covered	40% coinsurance	Requires prior authorization.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	40% coinsurance	Requires prior authorization.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	40% coinsurance	Requires prior authorization.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		CommunityCare Provider (Level 1) (You will pay the least)	Other Participating Provider (Level 2) (You will pay more)	Out-of-Network Provider (Level 3) (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% coinsurance	40% coinsurance	40% coinsurance	Requires prior authorization.
	<a href="#">Rehabilitation services</a>	20% coinsurance	40% coinsurance	40% coinsurance	Outpatient-Max 30 visits per calendar year (all levels combined). Inpatient-Max 30 days per calendar year (all levels combined). May require prior authorization.
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	Not covered	—————none—————
	<a href="#">Skilled nursing care</a>	20% coinsurance	40% coinsurance	40% coinsurance	Max 60 days per calendar year (all levels combined). Requires prior authorization.
	<a href="#">Durable medical equipment</a>	20% coinsurance	40% coinsurance	40% coinsurance	May require prior authorization.
	<a href="#">Hospice services</a>	20% coinsurance	40% coinsurance	40% coinsurance	Requires prior authorization.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not covered	—————none—————
	Children's glasses	Not Covered	Not Covered	Not covered	—————none—————
	Children's dental check-up	Not Covered	Not Covered	Not covered	—————none—————

### 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](#).)

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Dental care (Adult)</li> <li>• Habilitation services</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Weight loss programs</li> </ul> |
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#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Abortion services-All terminations of pregnancy (abortion) services provided by a licensed provider, including those for which federal funding is prohibited, are covered by this plan.</li> </ul> | <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Chiropractic care</li> <li>• Cosmetic surgery (medically necessary)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids (age limits apply)</li> <li>• Routine foot care (in connection with the treatment of diabetes)</li> </ul> |
|---|--|---|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Health Net's Customer Contact Center at 1-888-802-7001, submit a grievance form through [www.healthnet.com](http://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. You have the right at any time to file a complaint with or seek assistance from the Division of Financial Regulation. If you choose to do so, assistance is available. Contact the Division of Financial Regulation at PO Box 14480, Salem, OR 97309-0405. Contact them by phone at 1-503-947-7984 or toll free at 1-888-877-4894, by email at [cp.ins@state.or.us](mailto:cp.ins@state.or.us) or online at [www.cbs.state.or.us/ins/consumer/consumer.html](http://www.cbs.state.or.us/ins/consumer/consumer.html). 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 <https://www.dol.gov/ebsa/healthreform/>.

**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 1-888-802-7001.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-802-7001.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-802-7001.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-802-7001.

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

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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](#) \$1,500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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

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

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$80
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,140</b>

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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

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

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$600
Coinsurance	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,560</b>

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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

<b>Total Example Cost</b>	<b>\$2,500</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$200
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Health Net Health Plan of Oregon, Inc. (“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 1-888-802-7001 (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. Employer group members please call 1-888-802-7001 (TTY: 711).

**Amharic**

ከፍያ የሌለው የቋንቋ አገልግሎት። አስተርጓሚ ማግኘት ይችላሉ። ሰነዶች እንዲዘጋጅልዎ ማድረግ ይችላሉ። አርዳታ ለማግኘት በመታወቂያ ላይ ያለውን ቁጥር ይደውሉ። አመልካቾች 1-888-802-7001 (TTY: 711) ይደውሉ።

**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 مجموعة أصحاب العمل الاتصال على الرقم 1-888-802-7001 (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。雇主團體的會員請致電 1-888-802-7001 (TTY : 711)。

**Cushite (Oromo)**

Waa Lacag la'aan Adeegyada Luuqada. Waxaad heli kartaa turjubaan. Waxaad heli kartaa in waraaqaha lagu aqriyo. Wixii caawin ah, naga soo wac lambarka ku qoran kaarka Aqoonsigaaga. Xubnaha kooxda badrooniga fadlan soo wac 1-888-802-7001 (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. Arbeitgeber-Gruppenmitglieder rufen bitte unter 1-888-802-7001 (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。雇用主を通じた団体保険のメンバーの方は、1-888-802-7001 (TTY: 711) までお電話ください。

**Korean**

무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스도 받으실 수 있습니다. 도움을 원하시면, 보험 ID에 수록된 번호로 전화해 주십시오. 고용주 그룹 가입자분은 1-888-802-7001 (TTY: 711) 번으로 전화해 주십시오.

**Cambodian (Khmer)**

សេវាកាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរស័ព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក។ សមាជិកក្រុមនិយោជក សូមទាក់ទងទៅលេខ 1-888-802-7001 (TTY: 711)។

**Laotian**

ລິການພາສາບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງໄດ້. ເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ, ກະລຸນາໂທຫາພວກເຮົາໄດ້ຕາມເບີທີ່ມີຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ. ສະມາຊິກກຸ່ມນາຍຈ້າງ ກະລຸນາໂທຫາເບີ 1-888-802-7001 (TTY: 711).



## **Punjabi**

ਬਿਨਾਂ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਡੇ ਲਈ ਦਸਤਾਵੇਜ਼ਾਂ ਪੜ੍ਹੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਰੋਜ਼ਗਾਰਦਾਤਾ ਗਰੁੱਪ ਦੇ ਸਦੱਸ, ਕਿਰਪਾ ਕਰਕੇ 1-888-802-7001 (TTY: 711) 'ਤੇ ਫੋਨ ਕਰੋ।

## **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. Если вы участник коллективного плана, предоставляемого работодателем, звоните по телефону 1-888-802-7001 (TTY: 711).

## **Spanish**

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación. Los afiliados del grupo del empleador deben llamar al 1-888-802-7001 (TTY: 711).

## **Tagalog**

Walang Gastos na Mga Serbisyo sa Wika. Maaari kayong kumuha ng isang interpreter. Maaari ninyong ipabasa ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card. Para sa mga miyembro ng grupo ng employer, mangyaring tumawag sa 1-888-802-7001 (TTY: 711).

## **Ukrainian**

Безплатні послуги перекладу. Ви можете скористуватися послугами перекладача. Вам можуть прочитати ваші документи. Щоб отримати допомогу, телефонуйте нам за номером, який вказаний на вашій ідентифікаційній картці (ID). Учасників групового страхового плану від працедавця просимо телефонувати за номером 1-888-802-7001 (TTY: 711).

## **Vietnamese**

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu 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 thuộc chương trình theo nhóm của chủ sử dụng lao động vui lòng gọi số 1-888-802-7001 (TTY: 711).

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