SHP 2500 HDHP HMO Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Sutter Health Plan: Vista HL13 HDHP HMO

Sutter Health Plan
Coverage Period: 07/01/2026 – 06/30/2027
Coverage for: Large Group | Plan Type: HDHP HMO

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 Plan at 1-855-315-5800 or visit sutterhealthplan.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment (copay), deductible, provider, or other underlined terms, see the Glossary of Health Coverage and Medical Terms. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-855-315-5800 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,500** individual / **$3,400** individual family member / **$5,000** family for certain medical and pharmacy services per calendar year.	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.
Are there services covered before you meet your deductible?	Yes. Only preventive care is 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 (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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$4,000** individual / **$4,000** individual family member / **$8,000** family per calendar year.	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.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover and cost sharing for most optional benefits if elected by your employer group.	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.sutterhealthplan.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.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary Care Physician (PCP) Visit to treat an injury or illness	PCP Office Visit: 20% coinsurance Sutter Walk-in Care Visit: 20% coinsurance Telehealth Visit: 20% coinsurance	Not covered	Includes Other Health Professional visits. *See Definitions section in EOC for list of Other Health Professionals.
	Specialist Visit	Specialist Office Visit: 20% coinsurance Telehealth Visit: 20% coinsurance	Not covered	Prior authorization for some referrals to specialists is required. If it is not received, you may be responsible for paying all charges.
	Preventive Care / Screening / Immunization	No charge Deductible does not apply	Not covered	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)	Lab: 20% coinsurance X-ray: 20% coinsurance	Not covered	Prior authorization for some diagnostic services is required. If it is not received, you may be responsible for paying all charges.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	
If you need drugs to treat your illness or condition For information about prescription drug coverage,	Tier 1 (Most generic drugs and low-cost preferred brand name drugs)	Retail: $10 copay per prescription Mail Order: $20 copay per prescription	Not covered	Retail: covers up to a 30-day supply through a CVS Caremark contracted retail network pharmacy and covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through SHP's CVS Caremark Retail-90 Network.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
including the Sutter Health Plan (SHP) formulary, visit www.sutterhealthplan.org/pharmacy or call CVS Caremark at 1-844-740-0635.	Tier 2 (Preferred brand name drugs and non-preferred generic drugs)	Retail: $30 copay per prescription Mail Order: $60 copay per prescription	Not covered	Mail Order/home delivery service: covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through the CVS Caremark Mail Service Pharmacy. Most specialty drugs are covered up to a 30-day supply through a CVS Caremark contracted specialty pharmacy. Specialty drugs are not exclusive to Tier 4 and, regardless of tier placement, have the same fill requirements. *See SHP formulary or the Outpatient Prescription Drugs, Supplies, Equipment and Supplement section and Exclusions and Limitations section in EOC for any SHP policy requirements such as prior authorization and step therapy, or coverage limitations and exceptions.
	Tier 3 (Non-preferred brand name drugs)	Retail: $75 copay per prescription Mail Order: $150 copay per prescription	Not covered	
	Tier 4 (Specialty drugs, drugs that require special handling, or drugs that cost SHP more than $600 net of rebates)	20% coinsurance up to $250 per prescription	Not covered	
If you have outpatient surgery	Facility Fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Prior authorization is required. If it is not received, you may be responsible for paying all charges.
	Physician / Surgeon Fee	20% coinsurance	Not covered	
If you need immediate medical attention	Emergency Room Care	Facility: 20% coinsurance Professional: 20% coinsurance		If admitted to the hospital, Emergency Room Care cost sharing will not apply. See hospital stay information below for applicable cost sharing.
	Emergency Medical Transportation	20% coinsurance		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.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
	Urgent Care	20% coinsurance		For in-area Urgent Care, visit your Medical Group's contracted Urgent Care facility. For Out-of-Area Urgent Care, visit the nearest Urgent Care facility. Behavioral health crisis services provided by a 988 center or mobile crisis team, or other providers of behavioral health crisis services is covered in and out-of-network.
If you have a hospital stay	Facility Fee (e.g., hospital room)	20% coinsurance	Not covered	Prior authorization may be required. If it is not received, you may be responsible for paying all charges. Services that are part of a CARE agreement or plan approved by a court, or behavioral health crisis services from a 988 center or mobile crisis team or other providers of behavioral health crisis services, are covered in or out-of-network and without prior authorization.
	Physician / Surgeon Fees	20% coinsurance	Not covered	
If you need mental health, behavioral health, or substance use disorder (MH/SUD) services For information, call Carelon Behavioral Health of California, Inc (Carelon) at 844-398-0314 or visit carelonbh.com/sutterhealthplan.	Outpatient Services	Individual Office Visit: 20% coinsurance Group Office Visit: 20% coinsurance Telehealth Office Visit: 20% coinsurance Other Outpatient Services: 20% coinsurance	Not covered	You may self-refer to a Carelon provider for Office Visits. Prior authorization is required for Other Outpatient Services and all Inpatient Services by Carelon. If it is not obtained when required, you may be liable for the payment of services or supplies.
	Inpatient Services	Facility: 20% coinsurance Professional: 20% coinsurance	Not covered	Services that are part of a CARE agreement or plan approved by a court, or behavioral health crisis services from a 988 center or mobile crisis team or other providers of behavioral health crisis services, are covered in or out-of-network and without prior authorization.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
If you are pregnant	Office Visits	Prenatal and Postnatal Care (In-person or telehealth visit): No charge Deductible does not apply	Not covered	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).
	Childbirth / Delivery Professional Services	20% coinsurance	Not covered	None
	Childbirth / Delivery Facility Services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home Health Care	No charge	Not covered	Prior authorization is required. If it is not received, you may be responsible for paying all charges. Quantitative limits exist for the following services: Home Health Care – 100 visits per calendar year. Skilled Nursing Care – 100 days per benefit period. *See Skilled Nursing Facility Care section in EOC for additional information. Hospice Services – respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time.
	Rehabilitation Services	20% coinsurance	Not covered	
	Habilitation Services	Not covered	Not covered	
	Skilled Nursing Care	20% coinsurance	Not covered	
	Durable Medical Equipment	50% coinsurance	Not covered	
	Hospice Services	No charge	Not covered	
If your child needs dental or eye care For more information, contact Vision Services	Children's Eye Exam	No charge Deductible does not apply	Up to $45 max reimbursement	Quantitative limits exist for the following children's services: Eye Exam – 1 preventive exam per calendar year.
	Children's Glasses	Not covered	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
Plan (VSP) at 1-800-877-7195.	Children's Dental Check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan Evidence of Coverage (EOC) for more information and a list of any other excluded services.)

- Chiropractic care
- Commercial weight loss programs
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- 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 Evidence of Coverage (EOC).)

- Abortion
- Acupuncture typically provided only for the treatment of nausea or chronic pain; embedded in medical plan. PCP referral and prior authorization are required.
- Bariatric surgery
- Infertility treatment (coverage for the diagnosis and treatment of infertility and fertility services) embedded in medical plan. A PCP or OB/GYN referral and prior authorization by your medical group or SHP are required for medically necessary services. *See the Infertility and Fertility Services section of the Your Benefits chapter in your EOC for additional information.
- Routine eye care (Adult) limited to an annual preventive eye exam through VSP; embedded in medical plan.

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

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 Plan 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.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments (copays) and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

The plan's overall deductible	**$2,500**
Specialist copayment	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**50%**

This EXAMPLE event includes services like:
Office Visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services *(anesthesia)*
Diagnostic Tests (*ultrasounds and blood work)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductible	$2,500
Copayments	$10
Coinsurance	$1,400
What isn't covered	
Limits or excluded services	$60
The total Peg would pay is	**$3,970**

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

The plan's overall deductible	**$2,500**
Specialist copayment	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**50%**

This EXAMPLE event includes services like:
Primary Care Physician Office Visits (*including disease education)*
Diagnostic Tests *(blood work)*
Prescription Drugs *(including glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductible	$2,500
Copayments	$600
Coinsurance	$50
What isn't covered	
Limits or excluded services	$20
The total Joe would pay is	**$3,170**

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

The plan's overall deductible	**$2,500**
Specialist copayment	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**50%**

This EXAMPLE event includes services like:
Emergency Room Care *(including medical supplies)*
Diagnostic Tests *(X-ray)*
Durable Medical Equipment *(crutches)*
Rehabilitation Services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductible	$2,500
Copayments	$0
Coinsurance	$50
What isn't covered	
Limits or excluded services	$0
The total Mia would pay is	**$2,550**

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 Plan 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 Plan Customer Service at 855-315-5800 (TTY 855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plan puede proporcionarle a alguien que lo ayude a leerlo. También puede obtener este documento en su idioma. Llame al Servicio de Atención al Cliente de Sutter Health Plan al 855-315-5800 (TTY 855-830-3500). (Spanish)

重要事項：您能閱讀這些內容嗎？如果不能閱讀，Sutter Health Plan 可以安排人員幫助您閱讀。您還可能可以獲得以您的語言編寫的這些內容。如需免費幫助，請致電 Sutter Health Plan 客戶服務部，電話號碼：855-315-5800 (TTY 855-830-3500)。(Chinese)

ملحوظة مُهمّة: هل بمقدورك قراءة هذا؟ إذا لم تكن قادرًا على ذلك، يُمكن لخطّة Sutter Health Plan أن تستعين بشخص يساعدك على قراءته. كما قد يكون من الممكن أن تحصل على نسخة من هذا المستند مكتوبة بلغتك. للحصول على مساعدة مجّانية، يُرجى الاتصال بخدمة العُملاء لخطّة Sutter Health Plan على هاتف 855-315-5800 (أو خط الكتابة عن بُعد [TTY] 855-830-3500). (Arabic)

ԿԱՐԵՎՈՐ Է. Կարո՞ղ եք սա կարդալ: Եթե ոչ, Sutter Health Plan-ը կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն: Դուք կկարողանաք նաև ստանալ այն գրված Ձեր լեզվով: Անվճար օգնության համար զանգահարեք Sutter Health Plan-ի Հաճախորդների սպասարկման բաժին՝ 855-315-5800 (TTY 855-830-3500) հեռախոսահամարով: (Armenian)

សំខាន់៖ តើអ្នកអាចអានដាច់ទេ? បើអានមិនដាច់ទេ Sutter Health Plan អាចឲ្យគេជួយអ្នកអានបាន។ អ្នកក៏ប្រហែលជាអាចទទួលបានឯកសារនេះសរសេរជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទៅកាន់ផ្នែកសេវាអតិថិជន Sutter Health Plan តាមលេខ 855-315-5800 (TTY 855-830-3500)។ (Cambodian)

نکته مهم: آیا می‌توانید این مطلب را بخوانید؟ اگر نمی‌توانید، Sutter Health Plan می‌تواند از فردی کمک بگیرد تا آن را برایتان بخواند. همچنین امکان دریافت این مطالب به زبان شما وجود دارد. برای دریافت کمک به صورت رایگان، لطفاً با خدمات مشتریان Sutter Health Plan از طریق شماره تلفن 855-315-5800 (TTY 855-830-3500) تماس بگیرید. (Farsi)

महत्वपूर्ण: क्या आप इसे पढ़ सकते/ती हैं? यदि नहीं, तो सट्टर हेल्थ प्लान (Sutter Health Plan) इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा में भी लिखवा सकते/ती हैं। निःशुल्क सहायता के लिए, कृपया Sutter Health Plan ग्राहक सेवा को 855-315-5800 (TTY 855-830-3500) पर कॉल करें। (Hindi)

TSEEM CEEB: Koj puas tuaj yeem nyeem qhov no tau? Yog tias tsis tau, Sutter Health Plan tuaj yeem kom ib tus neeg pab koj nyeem nws. Tsis tas li ntawd, tej zaum koj kuj tseem tuaj yeem tau txais qhov no sau ua koj hom lus thiab. Yog xav tau kev pab dawb, thov hu rau Sutter Health Plan Lub Chaw Pab Cuam Qhua ntawm 855-315-5800 (TTY 855-830-3500). (Hmong)

重要：こちらの文書が読めますか？ 読むのが難しいときは、サッター ヘルス プランが読むのをお手伝いするスタッフを手配します。また、これを日本語で書いてもらうこともできます。無料でのサポートをご利用いただくには、電話 855-315-5800（TTY 855-830-3500）、サッター ヘルス プラン カスタマー サービスにご連絡ください。(Japanese)

중요 사항: 이것을 읽으실 수 있습니까? 만약 읽으실 수 없는 경우, Sutter Health Plan 은 귀하가 읽으실 수 있도록 다른 사람을 시켜 도와 드릴 수 있습니다. 또한 이 내용을 자신이 사용하는 언어로 작성하도록 하실 수도 있습니다. 비용 부담 없이 도움을 받으시려면 Sutter Health Plan 고객 서비스에 전화를 하십시오. 전화: 855-315-5800 (TTY 855-830-3500). (Korean)

ສຳຄັນ: ທ່ານສາມາດອ່ານຂໍ້ຄວາມນີ້ໄດ້ບໍ? ຖ້າບໍ່ໄດ້, Sutter Health Plan ສາມາດໃຫ້ຄົນຊ່ວຍທ່ານອ່ານຂໍ້ຄວາມນີ້. ນອກຈາກນີ້, ທ່ານຍັງອາດຈະສາມາດຂໍໃຫ້ຂຽນເປັນພາສາຂອງທ່ານໄດ້. ຫາກຕ້ອງການການຊ່ວຍເຫຼືອໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ, ກະລຸນາໂທຫາຝ່າຍບໍລິການລູກຄ້າຂອງ Sutter Health Plan ທີ່ 855-315-5800 (TTY 855-830-3500). (Laotian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਸੱਟਰ ਹੈਲਥ ਪਲਾਨ (Sutter Health Plan) ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਬਿਨਾਂ ਲਾਗਤ ਦੇ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਸੱਟਰ ਹੈਲਥ ਪਲਾਨ ਦੀ ਗਾਹਕ ਸੇਵਾ ਨੂੰ 855-315-5800 (TTY 855-830-3500) 'ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ВАЖНО. Вы можете это прочитать? Если нет, Sutter Health Plan может предоставить вам того, кто сможет помочь вам прочитать это. Вы также можете получить этот документ в письменной форме на своём языке. Для бесплатной помощи позвоните в отдел обслуживания клиентов Sutter Health Plan по телефону 855-315-5800 (TTY 855-830-3500). (Russian)

MAHALAGA: Nababasa mo ba ito? Kung hindi, maaari kang bigyan ng Sutter Health Plan ng taong makakatulong sa iyo na basahin ito. Maaari mo ring hilingin na ipasulat ito sa iyong wika. Para sa walang bayad na tulong, mangyaring tumawag sa Sutter Health Plan Customer Service sa 855-315-5800 (TTY 855-830-3500). (Tagalog)

หมายเหตุ: คุณอ่านข้อความนี้ออกหรือไม่ ถ้าหากคุณอ่านไม่ออก Sutter Health Plan สามารถให้คนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถขอรับเนื้อหานี้เป็นภาษาของคุณได้อีกด้วย หากคุณต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย กรุณาติดต่อ Sutter Health Plan Customer Service ได้ที่ 855-315-5800 (TTY 855-830-3500) (Thai)

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