A dental plan for individuals and families

A DHMO plan that gives you simpler benefits for a healthier smile

United Healthcare

We give you something to smile about

Your health benefits just aren't complete without dental coverage

Whether you need coverage for yourself or for a growing family, you'll appreciate UnitedHealthcare Dental Plan V160 plan that provides a wide range of benefits. Routine exams are covered at no charge. And the plan covers a range of preventive, routine and major services at a fraction of what you would pay without coverage. There's even an orthodontic plan with special pricing. Now, that's worth smiling about!

The UnitedHealthcare Dental Plan V160 plan is simple to use. There are no claim forms and no deductibles. Your annual premiums cover common dental procedures to keep your smile healthy. (See the Benefit & Copayment Highlights inside.)

The dentist just for you

When you join UnitedHealthcare Dental ("UnitedHealthcare Dental Plan V160 or The Plan"), you'll select a contracted dentist from our directory to oversee your dental care. All dentists are rigorously screened before they're added to our network. With our large DHMO California network, you're sure to find a dentist you're comfortable with at a location that's convenient for you.

Find your primary care dentist

Each family member can have their own primary care dentist. Before you enroll, search the network to find the dentist that is right for you.

Online

1. Go to **myuhc.com**
2. Select Find a Dentist
3. Select California
4. Select the "CA DHMO-Legacy PacifiCare" network

Call Open Enrollment Hotline at **1-888-679-8925.**

Brace yourself: orthodontia is included too

Straight teeth are important, not only for a great-looking smile, but also for the lifelong health of your teeth, gums and mouth. That's why UnitedHealthcare Dental V160 includes a value-priced orthodontic program. You pay a specially negotiated fee (most orthodontists accept payment plans), plus startup, retention and final records fees.

Your Plan primary care office submits a referral form. Then, the Plan sends you an Explanation of Benefits which includes the name and location of a contracted orthodontist who can provide the orthodontic treatment.

It's easy to enroll

1. Fill out the attached enrollment form and, if choosing the ACH method of payment, be sure to fill out the Pre-Authorization payment application.
2. Indicate which dental office you've chosen. Choose the dental office from our Dentist Directory by visiting myuhc.com or by calling **1-888-679-8925.**
3. Include a check for your enrollment fee and annual premium payable to UnitedHealthcare Dental. Make sure we receive your enrollment form and payment by the 20th of the month to ensure coverage begins the first of the following month.

   Send enrollment form and payment to:

   ATTN: M/S CA 120-0451
   UnitedHealthcare Dental
   P.O. Box 6020
   Cypress, CA 90630-0020

Make payments even easier

Select our monthly auto pay, which allows us to automatically debit your personal checking account each month. This payment option authorization can be found on the enrollment form inside.

2024 Dental V160 rates by region

You may select to pay on a monthly basis or save by making an annual payment.

	1	2	3
Region	Alameda, Contra Costa, El Dorado, Fresno, Kern, Los Angeles, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Ventura counties:	Butte, Marin, Solano, Sonoma, Stanislaus counties:	Monterey, San Louis Obispo, Santa Barbara, Tulare counties:
Monthly Pay			
Subscriber	$22.37	$51.91	$46.50
Subscriber + 1	$35.40	$82.14	$73.58
Family	$49.95	$115.90	$103.82
	Or save when you select the Annual Payment Option		
Annual Payment Option			
Subscriber	$259.04	$601.07	$538.43
Subscriber + 1	$409.93	$951.24	$852.11
Family	$578.42	$1,342.12	$1,202.27

For all other areas, please call **1-888-679-8925.**

Quality dental care.
Broad coverage.
Cost-effective premiums and copayments.

So, are you smiling yet?

Preventive services	Member pays:
Office visit	No Charge
X-rays, full mouth	No Charge
Single film	No Charge
Each additional film	No Charge
Teeth cleaning	No Charge
Topical fluoride (under age 18)	No Charge
Sealants (per tooth; under age 18)	Not Covered
Diagnostic casts (non-orthodontic)	$10.00
Emergency treatment (palliative)	$10.00
Office visit (after-hours)	$20.00
Routine services	
Restorative dentistry	
Amalgam restorations (cavities involving permanent teeth)	
One tooth surface	$15.00
Two tooth surfaces	$20.00
Three tooth surfaces	$26.00
Resin restorations, per tooth (anterior)	$25.00
As above, involving incisal edge	$28.00
Resin restorations, per tooth (posterior)	$66.00-$102.00
Pin retention in addition to final restoration, per tooth	$5.00
Sedative base	$7.00
Oral surgery	
Extraction (uncomplicated)	$16.00
Each additional tooth (same visit)	$10.00
Soft tissue impaction	$50.00
Partially bony impaction	Not Covered
Completely bony impaction	Not Covered
Biopsy of oral tissue (soft)	$10.00
Biopsy of oral tissue (hard)	$16.00
Surgical removal of an erupted tooth	$40.00
Alveoloplasty (not in conjunction with extractions), per quadrant	$80.00
Alveoloplasty in addition to tooth extraction, per quadrant	$90.00
Drain abscess/intraoral	$30.00
Drain abscess/extraoral	$30.00
Frenectomy	$50.00
Endodontics	
Pulp capping (direct)	$10.00
Pulp capping (indirect)	$24.00
Therapeutic pulpotomy	$22.00
Root canals - Anterior	$100.00
Root canals - Bicuspid	$130.00
Root canals - Molar	$175.00
Prefabricated post	$50.00
Cast post and core	$65.00
Periodontics	
Gingival curettage, per quadrant	$40.00
Gingivectomy, per quadrant	$115.00
Muco-gingival surgery, per quadrant	Not Covered
Gingivectomy, per tooth	$20.00
Periodontal maintenance (once every 6 months)	$20.00
Occlusion adjustment	No Charge

Major services	Member pays:
Crowns and pontics	
Stainless steel, primary tooth	$30.00
Resin crown†	$85.00
Full metal crown*	$145.00
3/4 metal crown*	$140.00
Porcelain crown†	$130.00
Porcelain with metal crown*†	$165.00
Cast post and core, in addition to crown*	$ 65.00
Pontic, cast metal (base)	$145.00
Pontic, porcelain with metal*	$165.00
Inlay recementation	$12.00
Crown recementation	$12.00
Bridge recementation	$18.00
Prosthetics	
Denture adjustment	$12.00
Replace tooth, per tooth	$23.00
Denture repair	$28.00
Denture reline (office)	$35.00
Denture reline, lab-processed	$65.00
Interim partial denture	$60.00
Partial denture, upper or lower (including any conventional clasps, rests, and teeth)*	$225.00
Partial denture (cast metal base with resin saddle), upper or lower (including any conventional clasps, rests, and teeth)*	$255.00
Complete denture, upper or lower	$250.00
Add tooth or clasp to existing partial	$31.00
Fixed space maintainer	$55.00
Removable acrylic space maintainer	$55.00
Clasps, each additional, for space maintainer	No Charge

*Plus actual lab cost of gold.

† Not for molars.

Dentist may charge $20.00 for broken appointments if not notified at least 24 hours in advance.

Orthodontics	
Class I (teeth straightening)	$1,895.00
Class II (correction of overbite)	$1,895.00
Class III (correction of underbite)	$1,895.00

Specific copayment levels also have been set for startup and retention services. The orthodontic benefit covers: consultation, retention, banding, and monthly office visits for 24 months.

Orthodontic treatment must be provided by a UnitedHealthcare Dental Panel Orthodontist. A referral must be submitted by the assigned general dentist, and an orthodontist will be assigned by UnitedHealthcare Dental.

Refer to the Evidence of Coverage and Disclosure Form booklet and the Orthodontic Information Sheet for complete details of benefits, exclusions, limitations, and plan description. There is no specialty referral for the UnitedHealthcare Dental V160 plan. Copayments are applicable at participating general dentist offices only.

The Dental premium includes expenses related to state and federal taxes, fees and assessments. It also may include additional new taxes, fees and assessments from the Affordable Care Act.

Individual member enrollment 2024

Instructions for completing enrollment form.

- **Check all appropriate boxes and print all information clearly.** (Please retain the brochure information until you receive your ID card.)
- **Subscriber: Fill out section completely.** Remember to indicate the Provider Number/Dentist/City you have selected.
- **Dependents:** All dependents you wish to be covered should be listed in this section with their selected Provider (Dentist).
- **Method of Payment:** Please indicate your preferred method of payment, Monthly Auto Pay, Monthly Pay by Check, Credit Card or Annual Payment. Should you choose the Monthly Auto Pay option, complete and sign the Pre-Authorized Payment Application on the adjacent page. UnitedHealthcare Dental will then automatically deduct the monthly premium from your checking account. Or, if you select the pay by check option, please include a check made payable to UnitedHealthcare Dental for the annual or monthly premium and one-time enrollment and processing fee of $15.00.
- **Terms and Conditions**: Read the Terms and Conditions on the adjacent page and sign in the box at the "X" on the bottom of this sheet. This form must be signed for coverage to be effective. Your payment and completed enrollment form must be received by the 20th of the month for coverage to be effective the 1st of the following month.

Effective Date

Subscriber (you)

Please complete all sections. This form cannot be processed if information is incomplete.

Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /	Home ( )

Mailing Address	City	State	ZIP Code	Work ( )

Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No

Email	Cell ( )

Dependents (your spouse and/or children)

Remember to select a provider. Be sure to read the terms.

1

Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /

Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No

2

Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /

Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No

3

Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /

Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No

4

Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /

Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No

Payor (if not you)

This section must be completed by the individual who will be responsible for paying for the plan.

Last Name	First Name	Middle Initial	Email Address

Address	City	State	ZIP Code

Be sure to read the terms and conditions on the following page, and sign at the "X" by this symbol:

Mail To:
ATTN: M/S CA 120-0451
UnitedHealthcare Dental
P.O. Box 6020
Cypress, CA 90630-0020

Telephone:
1-888-679-8925
Fax: **1-844-608-0601**

Terms and Conditions

Please complete all sections. This form cannot be processed if information is incomplete.

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical/dental malpractice (that is as to whether any dental services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and UnitedHealthcare Dental or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. However, in the event the amount in controversy in the dispute including any claims of damage is not greater than $5,000.00, such disputes are not subject to binding arbitration hereunder. Disputes in which more than $5,000.00 is in controversy will not be resolved by a lawsuit or resort to court process, except as applicable law may provide for judicial review of arbitration proceedings. By enrolling in UnitedHealthcare Dental, both member (including any heirs or assigns) and UnitedHealthcare Dental entities agree to waive the constitutional right to a jury trial and instead voluntarily agree to the use of binding arbitration as described in the Evidence of Coverage. Request for disenrollment or changes in coverage must be received in writing by the 20th of the month to be effective same month. You can fax, mail or email changes:

Fax: 1-844-608-0601

Email: individualdhmodental@uhc.com

Mail: ATTN: M/S CA 120-0451
UnitedHealthcare Dental
P.O. Box 6020
Cypress, CA 90630-0020

Method of payment

Please complete all sections. This form cannot be processed if information is incomplete.

☐ **Monthly Auto Pay.**
Complete the attached Pre-Authorized Payment Application and include a voided check. A one-time non-refundable enrollment and processing fee of $15.00 will be debited from your checking account along with your first month's premium.

☐ **Monthly Pay by Check.**
Include a check payable to UnitedHealthcare Dental for your monthly premium, including a one-time non-refundable enrollment and processing fee of $15.00.

☐ **Pay by Credit Card (over the Phone).**
Please circle one (one-time, recurring, annual). Includes a one-time non-refundable enrollment and processing fee of $15.00.

or **save** when you select the **Annual Payment Option...**

☐ **Annual Payment.**
Include a check payable to UnitedHealthcare Dental for your annual premium, including a one-time non-refundable enrollment and processing fee of $15.00.

UnitedHealthcare Dental Signature Value (HMO) Dental V160 plan is not available in all counties. All dental care must be provided by a network dentist; please check the dentist listing for available dentists. Benefits for the UnitedHealthcare Dental® Signature Value DHMO plans are offered and provided by Dental Benefit Providers of California, Inc.

Please complete all sections. This form cannot be processed if information is incomplete.

X

Subscriber Signature (This form must be signed by the Subscriber for coverage to be effective.) Date

Pre-Authorized Payment Application

Complete this section only if you want your monthly premium automatically deducted from your checking account and provide a voided check.

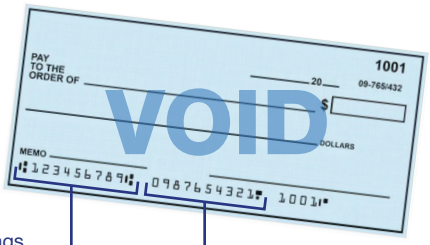
Our Pre-Authorized Payment Plan
It's the forget-proof method of paying your premium — almost as easy as payroll deduction. Just authorize us to debit your personal checking account each month. We'll do the rest. There will be no more paperwork for you and no more checks to write. No worries about monthly late-payment charges. And you'll save on postage and envelopes. It's easy, reliable and automatic.

2024 Calendar for Auto Debit

Jan 25	Apr 24	Jul 25	Oct 25
Feb 23	May 26	Aug 25	Nov 24
Mar 25	Jun 24	Sep 24	Dec 25

The auto debit process is 7 calendar days prior to the last day of the month except when that day is Saturday; then it will be Sunday. Please have your funds available for withdrawal on this day.

☐ **Automatic Payment(s)**
I (we) hereby authorize UnitedHealthcare to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account. I agree this authorization will remain in effect until you actually receive written notification of its termination from me.



Type of account: ☐ Checking ☐ Savings

Nine-digit Routing Number

Account Number

Financial Institution's Name _____

Address _____

City, State, ZIP _____

This auto debit process is 7 calendar days prior to the last day of the month except when that day is Saturday; then it will be Sunday. Please have your funds available for withdrawal on this day.

X _____
Authorized Account Signature

Agency/Broker Use Only

☐ **Agency** ☐ **Broker**

Name | ID Number | Phone

Address | City | State | ZIP Code

Email Address

Learn more

1-888-679-8925 | **uhc.com** Network name: CA DHMO-Legacy PacifiCare
ATTN: M/S CA 120-0451, UnitedHealthcare Dental, P.O. Box 6020, Cypress, CA 90630-0020

Nondiscrimination Notice and Access to Communication Services

We do not exclude, deny benefits to, or otherwise discriminate against any Member on the ground of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability for participation in, or receipt of the covered services under, any of its Plans, whether carried out by UnitedHealthcare directly or any other entity with which UnitedHealthcare arranges to carry out covered services under any of its Plans.

Free services are available to help you communicate with us such as letters in other languages and in other formats like large print. You can also ask for an interpreter at no charge. For assistance, please call the toll-free number listed on your plan ID card.

If you think you weren't treated fairly because of your race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can send a complaint to:

Online:
UHC_Civil_Rights@uhc.com

Mail:
Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your plan ID card, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**

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

Phone:
Toll-free 1-800-368-1019,
1-800-537-7697 (TDD)

Mail:
U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington, DC 20201

IMPORTANT LANGUAGE INFORMATION:
You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at the phone number listed on the back of your ID card, TTY 711. If you need more help, call DMHC Help Line at 1-888-466-2219.

INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:
Es probable que usted disponga de los derechos y servicios a continuación. Puede pedir un intérprete o servicios de traducción sin cargo. Es posible que tenga disponible documentación impresa en algunos idiomas sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud al número de teléfono que se encuentra en la parte de atrás de su tarjeta de ID, TTY 711. Si necesita más ayuda, llame a la Línea de Ayuda del DMHC al 1-888-466-2219.

重要語言資訊：
您可能有資格享有下列權利並取得下列服務。您可以免費獲取口譯員或翻譯服務。部分語言亦備有免費書面資訊。如欲以您的語言取得協助，請撥打您會員卡背面所列的健保計劃電話號碼，聽力語言殘障服務專線 (TTY) 711。如果您需要更多協助，請撥打 DMHC 服務專線 1-888-466-2219。

معلومات مهمة عن اللغة:
ربما تكون مؤهلاً للحصول على الحقوق والخدمات أدناه. فيمكنك الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. وربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. للحصول على مساعدة بلغتك، يُرجى الاتصال بخطتك الصحية على رقم الهاتف الموضح على الوجه الخلفي لبطاقة معرّف العضوية، TTY 711. إذا احتجت لمزيدٍ من المساعدة، يمكنك الاتصال بـ DMHC على الرقم 1-888-466-2219.

ԿԱՐԵՎՈՐ ԼԵԶՎԱԿԱՆ ՏԵՂԵԿՈՒԹՅՈՒՆ՝
Հավանական է, որ Ձեզ հասանելի լինեն հետևյալ իրավունքներն ու ծառայությունները: Կարող եք ստանալ բանավոր թարգմանչի կամ թարգմանության անվճար ծառայություններ: Հնարավոր է, որ մի շարք լեզուներով նաև առկա լինի անվճար գրավոր տեղեկություն: Ձեր լեզվով օգնություն ստանալու համար, խնդրում ենք զանգահարել Ձեր առողջապահական ծրագիր՝ Ձեր ճանաչողական քարտի հետևում նշված հեռախոսի համարով, TTY 711: Հավելյալ օգնության կարիքի դեպքում, զանգահարեք DMHC-ի Օգնության հեռախոսագծի 1-888-466-2219 համարով:

ព័ត៌មានសំខាន់អំពីភាសា៖
អ្នកអាចនឹងមានសិទ្ធិ ចំពោះសិទ្ធិ និងសេវានៅខាងក្រោម។ អ្នកអាចទទួលអ្នកបកប្រែ ឬសេវាការបកប្រែ ដោយឥតគិតថ្លៃ។ ព័ត៌មានដែលបានសរសេរ ក็អាចនឹងមានជាភាសាមួយចំនួន ដោយឥតគិតថ្លៃដែរ។ ដើម្បីទទួលជំនួយជាភាសារបស់អ្នក សូមហៅតំណាងសុខភាពរបស់អ្នក តាមលេខទូរស័ព្ទដែលកត់នៅខាងខ្នងនៃប័ណ្ណ ID របស់អ្នក TTY 711។ ប្រសិនអ្នកត្រូវការជំនួយថែមទៀត ហៅខ្សែទូរស័ព្ទជំនួយ DMHC តាមលេខ 1-888-466-2219។

اطلاعات مهم در مورد زبان:
شما ممکن است برای حقوق و خدمات زیر واجد شرایط باشید. می توانید خدمات مترجم شفاهی یا ترجمه را بدون پرداخت هزینه دریافت کنید. اطلاعات کتبی نیز ممکن است بدون پرداخت هزینه به برخی زبان ها موجود باشد. برای دریافت کمک و راهنمایی به زبان خودتان، لطفاً با برنامه درمانی به شماره ای که در پشت کارت شناسایی شما قید شده تماس بگیرید، TTY 711. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط تلفنی کمک و راهنمایی DMHC به شماره 1-888-466-2219 تماس بگیرید.

भाषा-संबंधी महत्वपूर्ण जानकारी:
आप निम्नलिखित अधिकारों और सेवाओं के हकदार हो सकते हैं। आपको मुफ़्त में एक दुभाषिया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में लिखित जानकारी भी मुफ़्त में उपलब्ध कराई जा सकती हैं। अपनी भाषा में सहायता पाने के लिए, कृपया अपनी स्वास्थ्य योजना को अपने आईडी कार्ड के पीछे दिए गए नंबर, TTY 711 पर कॉल करें। यदि आपको अधिक सहायता की आवश्यकता है, तो DMHC हेल्प लाइन को 1-888-466-2219 पर कॉल करें।

NCAUJ LUS TSEEM CEEB TXOG KEV TXUAS LUS:
Tej zaum koj yuav tsim nyog tau cov cai thiab kev pab cuam hauv qab no. Koj yuav tau ib tug kws txhais lus los sis txhais ntawv pub dawb. Yuav puav leej txhais tau cov ntaub ntawv ua qee hom lus pub dawb. Kom tau neeg pab txhais koj hom lus, thov hu rau koj lub chaw pab them nqi kho mob ntawm tus xov tooj sau rau nraum qab koj daim yuaj ID, TTY 711. Yog koj xav tau kev pab ntxiv, hu rau DMHC Tus Xov Tooj Pab ntawm 1-888-466-2219.

言語支援サービスについての重要なお知らせ：
お客様には、以下のような権利があり、必要なサービスをご利用いただけます。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された情報を無料でご利用できる場合もあります。英語以外の言語による支援をご希望の場合は、医療保険プランIDカードの裏面に記載されている番号（TTY 711）にお電話ください。さらに支援が必要な場合は、DMHCヘルプライン（1-888-466-2219）にお電話ください。

중요 언어 정보:
귀하는 아래와 같은 권리 및 서비스를 누리실 수 있습니다. 귀하는 통역 혹은 번역 서비스를 비용 부담없이 이용하실 수 있습니다. 일부 언어의 경우 서면 번역 서비스 또한 비용 부담없이 제공될 수도 있습니다. 귀하가 사용하는 언어로 도움을 받으시려면 귀하의 ID 카드 뒷면에 기재된 전화번호(TTY 711)로 귀하의 건강보험에 전화하십시오. 더 많은 도움이 필요하신 경우 DMHC 헬프라인 전화 1-888-466-2219번으로 전화하십시오.

ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਦੀ ਜਾਣਕਾਰੀ:
ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਬਿਨਾ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮਿਲ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਆਪਣੇ ਆਈਦੀ ਕਾਰਡ ਦੇ ਪਿਛਲੇ ਪਾਸੇ ਦਿੱਤੇ ਗਏ ਫੋਨ ਨੰਬਰ, TTY 711 ਤੇ ਕਾਲ ਕਰੋ। ਜੇ ਤੁਹਾਨੂੰ ਵਧੇਰੇ ਸਹਾਇਤਾ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ DMHC ਹੈਲਪ ਲਾਈਨ ਨੂੰ 1-888-466-2219 ਤੇ ਕਾਲ ਕਰੋ।

ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:
Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на родном языке, позвоните в свой план медицинского страхования по телефону, указанному на обороте вашей идентификационной карты. Линия TTY: 711. Если вопрос решить не удалось, позвоните в справочную службу DMHC по телефону 1-888-466-2219.

MAHALAGANG IMPORMASYON SA WIKA:
Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng interpreter o mga serbisyo sa pagsasalin nang walang bayad. Maaaring may available ding libreng nakasulat na impormasyon sa ilang wika. Upang humingi ng tulong sa iyong wika, mangyaring tumawag sa iyong planong pangkalusugan sa numero ng telepono makikita sa likod ng iyong ID card, para sa gumagamit ng TTY, sa 711. Kung kailangan mo ng higit pang tulong, tumawag sa Linya ng Tulong ng DMHC sa 1-888-466-2219.

ข้อมูลสำคัญเกี่ยวกับภาษา :
คุณอาจมีสิทธิ์ได้รับสิทธิและบริการต่าง ๆ ด้านล่างนี้ คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ ยังอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ โปรดโทรศัพท์ถึงแผนสุขภาพของคุณที่หมายเลขโทรศัพท์ที่อยู่ด้านหลังของบัตรประจำตัวของคุณ หรือหมายเลข 711 สำหรับผู้มีปัญหาทางการได้ยิน หากคุณต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ช่วยเหลือของ DMHC ที่หมายเลข 1-888-466-2219

THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:
Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu được cung cấp một thông dịch viên hoặc các dịch vụ dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể sẵn có ở một số ngôn ngữ miễn phí. Để được trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị theo số điện thoại được ghi trên mặt sau thẻ ID của quý vị, TTY 711. Nếu quý vị cần thêm trợ giúp, vui lòng gọi Đường dây trợ giúp DMHC theo số 1-888-466-2219.

This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your employer or the company.

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