



## Plan Design for: Davison Community Schools District

**Original Plan Effective Date: December 1, 2017**

**Network: PDP Plus**

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

|                                     | In-Network <sup>1</sup>  | Out-of-Network <sup>1</sup>  |
|-------------------------------------|--|--|
| <b>High Plan</b>                    |  |  |
| <b>Coverage Type:</b>               | <b>In-Network<br/>% of Negotiated Fee<sup>2</sup></b>                    | <b>Out-of-Network<sup>1</sup><br/>% of R&amp;C Fee<sup>4</sup></b> |
| <b>Type A - Preventive</b>          | 80%  | 80%  |
| <b>Type B - Basic Restorative</b>   | 80%  | 80%  |
| <b>Type C - Major Restorative</b>   | 80%  | 80%  |
| <b>Type D – Orthodontia</b>         | 70%  | 70%  |
| <b>Deductible<sup>3</sup></b>       |  |  |
| Individual                          | \$0  | \$0  |
| Family                              | \$0  | \$0  |
| <b>Annual Maximum Benefit:</b>      |  |  |
| Per Individual                      | \$1000   | \$1000   |
| <b>Orthodontia Lifetime Maximum</b> | Ortho applies to Child Only<br>Child to age 19                           |  |
|                                     | \$1500 per Person  | \$1500 per Person  |
| <b>Dependent Age:</b>               | Eligible for benefits until the end of the year that he or she turns 26. |  |
| <b>Low Plan</b>                     |  |  |
| <b>Coverage Type:</b>               | <b>In-Network<br/>% of Negotiated Fee<sup>2</sup></b>                    | <b>Out-of-Network<sup>1</sup><br/>% of R&amp;C Fee<sup>4</sup></b> |
| <b>Type A - Preventive</b>          | 50%  | 50%  |
| <b>Type B - Basic Restorative</b>   | 50%  | 50%  |
| <b>Type C - Major Restorative</b>   | 50%  | 50%  |
| <b>Type D – Orthodontia</b>         | 70%  | 70%  |
| <b>Deductible<sup>3</sup></b>       |  |  |
| Individual                          | \$0  | \$0  |
| Family                              | \$0  | \$0  |
| <b>Annual Maximum Benefit:</b>      |  |  |
| Per Individual                      | \$1000   | \$1000   |
| <b>Orthodontia Lifetime Maximum</b> | Ortho applies to Child Only<br>Child to age 19                           |  |
|                                     | \$1500 per Person  | \$1500 per Person  |
| <b>Dependent Age:</b>               | Eligible for benefits until the end of the year that he or she turns 26. |  |

1. "In-Network Benefits" means benefits provided under this plan for covered dental services that are provided by a MetLife PDP dentist.  
 "Out-of-Network Benefits" means benefits provided under this plan for covered dental services that are not provided by a MetLife PDP dentist.

2. PDP Fee refers to the fees that MetLife PDP dentists have agreed to accept as payment in full.

**High Plan**

3. Applies to Type B and C services only.

4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:

- the dentist's actual charge (the 'Actual Charge'),
- the dentist's usual charge for the same or similar services (the 'Usual Charge') or
- the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 80th percentile. Services must be necessary in terms of generally accepted dental standards.

**Low Plan**

3. Applies to Type B and C services only.

4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:

- the dentist's actual charge (the 'Actual Charge'),
- the dentist's usual charge for the same or similar services (the 'Usual Charge') or
- the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 80th percentile. Services must be necessary in terms of generally accepted dental standards.

## Understanding Your Dental Benefits Plan

The Preferred Dentist Program is designed to provide the dental coverage you need with the features you want. Like the freedom to visit the dentist of your choice – in or out of the network. .

If you receive in-network services, you will be responsible for any applicable cost sharing, negotiated charges after benefit maximums are met, and costs for non-covered services. If you receive out-of-network services, you will be responsible for any applicable cost sharing, charges in excess of the benefit maximum, charges in excess of the negotiated fee schedule amount, and charges for non-covered services.

- Plan benefits for in-network covered services are based on a percentage of the Negotiated fee – the Fee that participating dentists have agreed to accept as payment in full for covered services, subject to any deductibles, copayments, cost sharing and benefit maximums. Negotiated fees are subject to change.
- Plan benefits for out-of-network services are based on a percentage of the Reasonable and Customary (R&C) charge. If you choose a dentist who does not participate in the network, your out-of-pocket expenses may be greater.

### **Once you're enrolled you may take advantage of online self-service capabilities with MyBenefits.**

- Check the status of your claims
- Locate a participating dentist
- Access MetLife's Oral Health Library
- Elect to view your Explanation of Benefits online

To register, just go to  
**[www.metlife.com/mybenefits](http://www.metlife.com/mybenefits)**  
and follow the easy registration instructions.

## Selected Covered Services and Frequency Limitations\*

### High Plan

#### Type A - Preventive

#### How Many/How Often:

|                                |   |
|--------------------------------|---|
| Oral Examinations              | 2 in a year   |
| Full Mouth X-rays              | 1 in 60 months  |
| Bitewing X-rays (Adult/Child)  | 2 in a year   |
| Prophylaxis - Cleanings        | 2 in a year   |
| Topical Fluoride Applications  | 2 a year  |
| Sealants                       | 1 in 36 months - Children to age 19                   |
| Space Maintainers              | 1 per lifetime per tooth area - Children up to age 19 |
| Emergency Palliative Treatment |   |

#### Type B - Basic Restorative

#### How Many/How Often:

|                                     |                                   |
|-------------------------------------|-----------------------------------|
| Amalgam and Composite Fillings      | 1 in 24 months.                   |
| Endodontics Root Canal              | 1 per tooth in 24 months          |
| Periodontal Surgery                 | 1 in 60 months per quadrant       |
| Periodontal Scaling & Root Planing  | 1 in 24 months per quadrant       |
| Periodontal Maintenance             | 4 in 1 year, includes 2 cleanings |
| Oral Surgery (Simple Extractions)   |                                   |
| Oral Surgery (Surgical Extractions) |                                   |
| Other Oral Surgery                  |                                   |
| General Anesthesia                  |                                   |

#### Type C - Major Restorative

#### How Many/How Often:

|                      |   |
|----------------------|---|
| Crowns/Inlays/Onlays | 1 per tooth in 60 months                                  |
| Prefabricated Crowns | 1 per tooth in 60 months                                  |
| Bridges              | 1 in 60 months  |
| Dentures             | 1 in 60 months  |
| Consultations        | 1 in 12 months  |
| Implant Services     | 1 service per tooth in 60 months - 1 repair per 60 months |

#### Type D – Orthodontia

- Dependent children up to age 19. Age limitations may vary by state. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment, are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount as defined in the Plan Summary.
- Orthodontic benefits end at cancellation of coverage

**\*Alternate Benefits:** Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you receive a more costly treatment alternative, your dentist may charge you or your dependent for the difference between the cost of the service that was performed and the least costly treatment alternative.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description/Insurance certificate for complete details. In the event of a conflict with this summary, the terms of your insurance certificate will govern.

## Selected Covered Services and Frequency Limitations\*

### Low Plan

#### Type A - Preventive

#### How Many/How Often:

|                                |   |
|--------------------------------|---|
| Oral Examinations              | 2 in a year   |
| Full Mouth X-rays              | 1 in 60 months  |
| Bitewing X-rays (Adult/Child)  | 2 in a year   |
| Prophylaxis - Cleanings        | 2 in a year   |
| Topical Fluoride Applications  | 2 a year  |
| Sealants                       | 1 in 36 months - Children to age 19                   |
| Space Maintainers              | 1 per lifetime per tooth area - Children up to age 19 |
| Emergency Palliative Treatment |   |

#### Type B - Basic Restorative

#### How Many/How Often:

|                                     |                                   |
|-------------------------------------|-----------------------------------|
| Amalgam and Composite Fillings      | 1 in 24 months.                   |
| Endodontics Root Canal              | 1 per tooth in 24 months          |
| Periodontal Surgery                 | 1 in 60 months per quadrant       |
| Periodontal Scaling & Root Planing  | 1 in 24 months per quadrant       |
| Periodontal Maintenance             | 4 in 1 year, includes 2 cleanings |
| Oral Surgery (Simple Extractions)   |                                   |
| Oral Surgery (Surgical Extractions) |                                   |
| Other Oral Surgery                  |                                   |
| General Anesthesia                  |                                   |

#### Type C - Major Restorative

#### How Many/How Often:

|                      |   |
|----------------------|---|
| Crowns/Inlays/Onlays | 1 per tooth in 60 months                                  |
| Prefabricated Crowns | 1 per tooth in 60 months                                  |
| Bridges              | 1 in 60 months  |
| Dentures             | 1 in 60 months  |
| Consultations        | 1 in 12 months  |
| Implant Services     | 1 service per tooth in 60 months - 1 repair per 60 months |

#### Type D – Orthodontia

- Dependent children up to age 19. Age limitations may vary by state. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment, are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount as defined in the Plan Summary.
- Orthodontic benefits end at cancellation of coverage

**\*Alternate Benefits:** Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you receive a more costly treatment alternative, your dentist may charge you or your dependent for the difference between the cost of the service that was performed and the least costly treatment alternative.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description/Insurance certificate for complete details. In the event of a conflict with this summary, the terms of your insurance certificate will govern.

## We will not pay Dental Insurance benefits for charges incurred for:

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (For residents of Texas, see notice page section in your certificate).
5. Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - scaling and polishing of teeth; or
  - fluoride treatments.**For NY Situated Groups, this exclusion does not apply.**
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services
  - covered under any workers' compensation or occupational disease law;
  - covered under any employer liability law;
  - for which the employer of the person receiving such services is not required to pay; or
  - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.**For North Carolina and Virginia Situated Groups, this exclusion does not apply.**
14. Services paid under any worker's compensation, occupational disease or employer liability law as follows:
  - for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' compensation Act;
  - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.**This exclusion only applies for North Carolina Situated Groups.**
15. Services:
  - for which the employer of the person receiving such services is not required to pay; or
  - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.**This exclusion only applies for North Carolina Situated Groups.**
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the employee/or Dependent received benefits under that law.  
**This exclusion only applies for Virginia Situated Groups.**
17. Services:
  - for which the employer of the person receiving such services is not required to pay; or
  - received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital.**This exclusion only applies for Virginia Situated Groups.**
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
21. Prescription drugs.
22. Services for which the submitted documentation indicates a poor prognosis.
23. The following when charged by the Dentist on a separate basis:
  - claim form completion;
  - infection control such as gloves, masks, and sterilization of supplies; or
  - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
24. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.  
**For NY Situated Groups, this exclusion does not apply.**
25. Caries susceptibility tests.
26. Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
27. Other fixed Denture prosthetic services not described elsewhere in this certificate.
28. Precision attachments, except when the precision attachment is related to implant prosthetics.
29. Initial installation or replacement of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
30. Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
31. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
32. Implants to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.

33. Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
34. Fixed and removable appliances for correction of harmful habits.<sup>1</sup>
35. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.<sup>1</sup>
36. Orthodontic services or appliances.<sup>1</sup>
37. Repair or replacement of an orthodontic device.<sup>1</sup>
38. Duplicate prosthetic devices or appliances.
39. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
40. Intra and extraoral photographic images.
41. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms "Referral", "Health Care Practitioner", "Health Care Entity", "Beneficial Interest" and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.

**This exclusion only applies for Maryland Sitused Groups**

<sup>1</sup>Some of these exclusions may not apply. Please see your plan design and certificate for details.

## Common Questions ... Important Answers

### Who is a participating dentist?

A participating, or network, dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members, subject to any deductibles, copayments, cost sharing and benefit maximums. Negotiated fees typically range from 15-45% below the average fees charged in a dentist's community for the same or substantially similar services.\*

In addition to the standard MetLife network, your employer may provide you with access to a select network of dental providers that may be unique to your employer's dental program. When visiting these providers, you may receive a better benefit, have lower out-of-pocket costs and/or have access to care at facilities at your worksite. Please sign into MyBenefits for more details.

\* Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan how often members visit participating dentists and the cost of services rendered. Negotiated fees are subject to change.

### How do I find a participating dentist?

There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at [www.metlife.com/dental](http://www.metlife.com/dental) or call 1-800-275-4638 to have a list faxed or mailed to you.

### What services are covered by my plan?

All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits summary to learn more.\*

\*The information in this document represents an overview of your plan benefits, but is not a complete description of the plan. Before making any purchase or enrollment decision you should review the certificate of insurance which is available through MetLife or your employer. In the event of a conflict between this overview and your certificate of insurance, your certificate of insurance governs.

### May I choose a non-participating dentist?

Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating (out-of-network) dentist, your out-of-pocket costs may be higher.

### Can my dentist apply for participation in the network?

Yes. If your current dentist does not participate in the network and you would like to encourage him or her to apply, ask your dentist to visit [www.metdental.com](http://www.metdental.com), or call 1-866-PDP-NTWK for an application.\* The website and phone number are for use by dental professionals only.

\* Due to contractual requirements, MetLife is prevented from soliciting certain providers.

### How are claims processed?

Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit [www.metlife.com/dental](http://www.metlife.com/dental) or request one by calling 1-800-275-4638.

### Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of \$300. Simply have your dentist submit a request online at [www.metdental.com](http://www.metdental.com) or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

### Can MetLife help me find a dentist outside of the U.S. if I am traveling?

Yes. Through international dental travel assistance services\* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.\*\* Please remember to hold on to all receipts to submit a dental claim.

\*International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. (AXA Assistance). AXA Assistance provides dental referral services only. AXA Assistance is not affiliated with MetLife and any of its affiliates, and the services they provide are separate and apart from the benefits provided by MetLife. Referral services are not available in all locations.

\*\* Refer to your dental benefits plan summary for your out-of-network dental coverage.



**How does MetLife coordinate benefits with other insurance plans?**

Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions requires MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.

**Do I need an ID card?**

No, You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in a MetLife Dental Plan. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

**Do my dependents have to visit the same dentist that I select?**

No. You and your dependents each have the freedom to choose any dentist.

**If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?**

Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

- No waiting period on Preventive Services
- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

The information contained herein is a summary of the provisions of a MetLife Dental Plan. For complete terms and provisions of the plan, please see your certificate of insurance, the terms of which shall govern in all instances.

**CALIFORNIA HEALTHCARE LANGUAGE ASSISTANCE PROGRAM  
NOTICE TO INSURED**

**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, if any, or 1-800-942-0854. For more help call the CA Dept. of Insurance at 1-800-927-4357.  
To receive a copy of the attached MetLife document translated into Spanish or Chinese, please mark the box by the requested language statement below, and mail the document with this form to:

Metropolitan Life Insurance Company  
PO Box 14587  
Lexington, KY 40512

Please indicate to whom and where the translated document is to be sent.

**Servicio de Idiomas Sin Costo.** Puede obtener la ayuda de un intérprete. Se le pueden leer documentos y enviar algunos en español. Para recibir ayuda, llámenos al número que aparece en su tarjeta de identificación, si tiene una, o al 1-800-942-0854. Para recibir ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357.  
Para recibir una copia del documento adjunto de MetLife traducido al español, marque la casilla correspondiente a esta oración, y envíe por correo el documento junto con este formulario a:  
Metropolitan Life Insurance Company  
PO Box 14587  
Lexington, KY 40512  
Por favor, indique a quién y a dónde debe enviarse el documento traducido.  
NOMBRE \_\_\_\_\_  
DIRECCIÓN \_\_\_\_\_

**免費語言服務。** 您可獲得免費口譯服務。您可要求翻譯員向你口譯文件，或可要求向你發回文件的中文譯本。如需協助，請致電您的ID卡上所示號碼（如有），或 1-800-942-0854。如需更多協助，請致電加州保險部熱線 1-800-927-4357。  
為收取隨附MetLife文件的中文譯本，請勾選此陳述前的方格，並將文件連同此表一併郵寄至：  
Metropolitan Life Insurance Company  
PO Box 14587  
Lexington, KY 40512  
請指明經翻譯文件收件人的姓名及地址。  
姓名 \_\_\_\_\_  
地址 \_\_\_\_\_

**Անվճար թարգմանական ծառայություններ:** Ձեզ կտրամադրվի հայերենի թարգմանիչ, որի օգնությամբ կարող եք հայերենով կարդալ փաստաթղթերը: Հարցերի դեպքում զանգահարեք մեզ 24 Ըր ID քարտի վրա նշված հեռախոսահամարով կամ 1-800-942-0854: Առավել մանրամասն տեղեկություններ խնայն համար զանգահարեք Կալիֆոռնիայի Ապահովագրական Դեպարտամենտ 1-800-927-4357 հեռախոսահամարով:

**សេវាបកប្រែដោយឥតគិតថ្លៃ ។** អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងឱ្យគេអានឯកសារនានាឱ្យអ្នកស្តាប់ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខជំនួយ មានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នកប្រសិនបើមាន ឬ តាមលេខ 1-800-942-0854 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងពាណិជ្ជកម្មនៃរដ្ឋកាលីហ្វ័រញ៉ា (CA Dept. of Insurance) តាមលេខ 1-800-927-4357 ។

**Кев паб бхais lus tsis kom them nqi.** Koj thov tau kom nrhiv neeg bхais lus thiab nyeem ntaub ntawm hais ua lus Hmoob rau koj moog. Yog xav tau kev pab, hu rau peb ntawm tus xov toj sau hauv koj daim npav ID, yog muaj, lossis 1-800-942-0854. Yog xav kom pab lwm yam hu rau lub CA Hauv Paus Iv-saws-ias ntawm 1-800-927-4357.

**無料の通訳サービス。** 通訳を通して日本語で文書を読み上げてもらうことができます。サービスの利用をご希望の方は、お手持ちのIDカードに記載されている番号、または1-800-942-0854へお電話ください。さらなる支援が必要な場合は、カリフォルニア州保険庁 1-800-927-4357までお問い合わせください。

**무료 통역 서비스.** 통역자가 문서를 한국어로 읽어드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 있는 번호나 1-800-942-0854로 전화하십시오. 다른 도움이 필요하시면, 전화번호 1-800-927-4357로 캘리포니아 보험국에 연락하여 주십시오.

**Бесплатные услуги устного перевода.** Вы можете воспользоваться услугами переводчика, который прочитает вам документы на русском языке. Чтобы получить помощь, позвоните нам по номеру, указанному на вашей идентификационной карточке, если у вас она есть, либо по номеру 1-800-942-0854. Если вам нужна помощь в других вопросах, позвоните в горячую линию Департамента страхования (CA Dept. of Insurance) 1-800-927-4357.

**Libreng serbisy sa pagsasalín.** Maaari kang kumuha ng tagasalin para basahin sa iyong mga dokumento sa wikang Tagalog. Para ikaw ay matulungan, tawagan kami sa numerong nakalista sa iyong ID card, kung mayroon man, o sa numerong 1-800-942-0854. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa numerong 1-800-927-4357.

**Dịch vụ thông dịch miễn phí.** Quý vị có thể tìm một thông dịch viên và nhờ đọc các tài liệu này cho quý vị bằng tiếng Việt. Để được giúp đỡ, gọi cho chúng tôi tại số nếu trên thẻ ID của quý vị, nếu có, hoặc 1-800-942-0854. Để được giúp đỡ thêm gọi cho Ban Bảo Hiểm CA tại số 1-800-927-4357.

**لا تتوفر خدمات ترجمة بتكلفة.** يمكنك الاتصال بمترجم والحصول على خدمة قراءة المستندات باللغة العربية. للمساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك، أو اتصل بالرقم 1-800-942-0854. ولمزيد من المساعدة، اتصل بقسم التأمينات التابع لـ CA على الرقم 1-800-927-4357.  
**سرویس های ترجمه رایگان.** شما می توانید مترجم و اسنادی را به زبان فارسی برای مطالعه دریافت کنید. برای راهنمایی، از طریق شماره درج شده در کارت شناسایی خود (در صورت وجود) یا شماره 1-800-942-0854 با ما تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه کالیفرنیا 1-800-927-4357 تماس بگیرید.

**பலா மொழி மொழிபெயர்ப்பு சேவைகள் இலவசமாக கிடைக்கின்றன.** உங்களுக்குத் தேவையான ஆவணங்களை உங்களுக்குத் தேவையான மொழியில் வாசித்துக் கொடுக்க முடியும். உங்களுக்குத் தேவையான உதவியைப் பெற, உங்களுக்கு உள்ள ID கார்டில் உள்ள எண், அல்லது 1-800-942-0854-க்குத் தலைப்பிடுக. உங்களுக்குத் தேவையான உதவியைப் பெற, 1-800-927-4357-க்குத் தலைப்பிடுக.  
**گربھو، دے وچ نمبر یا 1-800-942-0854 پہ کال کرو۔ آگے مزید مدد واسطے اے نمبر 1-800-927-4357 پہ سی اے ڈیپارٹمنٹ برائے انشورنس نال گال کرو۔**