



## California Essential Health Benefit – PPO Family with EHB (for Children)

This summary of benefits, along with the exclusions and limitations describe the benefits of the California Family Dental PPO Policy. Please review closely to understand all benefits, exclusions and limitations. Member Cost Share amounts describe the Enrollee's out of pocket costs.

Child-ONLY* Essential Health Benefit	Member Cost Share In-Network	Covered Percentage In Network	Member Cost Share Out-of-Network**	Covered Percentage Out-of-Network**
<b>Class I/Preventive</b> - Cleanings, Exams, Fluoride, Sealants, Space Maintainers, Emergency Pain, and Radiographs (Bitewings, Full Mouth X-ray, Panoramic Film).	0%	100%	10%	90%
<b>Class II/Basic</b> - Restorations (Amalgams and Anterior Resins) and Periodontal Maintenance.	20%	80%	30%	70%
<b>Class III/Major</b> - Simple Extractions, Surgical Extractions, Oral Surgery, Anesthesia (General Anesthesia and Intravenous Sedation), Periodontics, Endodontics, Inlay, Onlays, Crowns, Crown Repair, Bridges, Bridge Repairs, Dentures and Denture Repair.	50%	50%	50%	50%
<b>Class IV/Orthodontia</b> (Only for pre-authorized Medically Necessary Orthodontia)	50%	50%	50%	50%
Deductible (waived for Class I)(per person)	\$75	N/A	\$75	N/A
Family Deductible (waived for Class I)(2+ children)	\$150	N/A	\$150	N/A
Out of Pocket Maximum (OOP) (per person)	\$350	N/A	N/A	N/A
Family Out of Pocket Maximum*** (OOP) (2+ children)	\$700	N/A	N/A	N/A
Annual Maximum	N/A			
Ortho Lifetime Maximum	N/A			
Waiting Period	N/A			
* This Policy is available for individuals up to age 19.				
**Benefits are based on the Usual and Customary charges of the majority of dentists in the same geographic area.				
***2 family members must each meet the out of pocket maximum in a Policy year. Once fulfilled the family maximum has been met and will not be applied to additional family members				

**THERE IS NO OUT OF POCKET MAXIMUM WHEN SERVICES ARE RECEIVED OUT-OF-NETWORK.**



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Adult-ONLY* PPO Benefit	Member Cost Share In-Network	Covered Percentage In Network	Member Cost Share Out-of-Network**	Covered Percentage Out-of-Network**
<b>Class I/Preventive</b> - Cleanings, Exams, Emergency Pain, Radiographs-Bitewings and Radiographs (Full Mouth X-ray, Panoramic Film).	0%	100%	10%	90%
<b>Class II/Basic</b> - Restorations (Amalgams & Anterior Resin) and Periodontal Maintenance.	20%	80%	30%	70%
<b>Class III/Major</b> - Inlay, Onlays, Crowns, Crown Repair, Bridges, Bridge Repairs, Dentures, Denture Repair, Simple Extractions, Surgical Extractions, Oral Surgery, Endodontics, Periodontics and Anesthesia.	50%	50%	50%	50%
<b>Class IV/Orthodontia</b>	N/A			
Deductible (waived for Class I)	\$50			
Family Deductible (waived for Class I)(2+ children)	N/A			
Out of Pocket Maximum (OOP) (per person)	N/A			
Out of Pocket Maximum (OOP) (per family - 2+ children)	N/A			
Annual Maximum	\$1,500			
Ortho Lifetime Maximum	N/A			
Waiting Period	6 months for Major Services (Waived with proof of prior coverage)***			
<p><i>* This Policy is available for individuals ages 19 and over.</i></p> <p><i>**Benefits are based on the Usual and Customary charges of the majority of dentists in the same geographic area.</i></p> <p><i>*** Prior coverage with a group plan not more than 30 days lapse prior to effective date.</i></p>				



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**The service area includes the following counties in California:** Alameda, Amador, Butte, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Kern, Kings, Lake, Los Angeles, Madera, Marin, Merced, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura, Yolo and Yuba.

### Provider Availability

If a network general or specialist dentist is unavailable and the member has no option but to receive medically necessary covered treatment from a non-network general or specialist dentist, We will be available to assist a member in identifying a non-network general or specialist dentist and will cover the treatment at the in-network cost share, which includes applicability of the in-network deductible and out-of-pocket maximum. Consideration for in-network reimbursement of treatment performed by a non-network general or specialist dentist will be limited to covered medically necessary dental services. Please refer to the provider directory for a complete listing of Our contracted dentists. Or you may access [DentalExchange.guardianlife.com](http://DentalExchange.guardianlife.com) to view Premier Access contracted dentists.

We shall provide accessibility to dentally required specialists who are certified or eligible for certification by the appropriate specialty board, through contracting or referral. The provider accessibility standards are as follows:

1. A general dentist is not located: a) within 30 minutes or 15 miles of a member's home or place of employment;
2. A specialist dentist is not located: a) within 60 minutes or 30 miles of a member's home or place of employment;
3. Urgent appointments are not available within 72 hours of the time of request for appointment, when consistent with the member's individual needs and as required by professionally recognized standards of practice;
4. Non-urgent appointments are not available within 36 business days of the request for appointment; and
5. Preventive appointments are not available within 40 business days of the request for appointment.

We will verify information related to the notification from the member that a network general or specialist dentist was not available within the parameters above. The information verified may include, but may not be limited to, review of the network general and specialist dentists available within the required driving distance from the member's home or place of employment. The applicable waiting time for a particular appointment may be extended if the referring or treating dentist, acting within the scope of the dentist's practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the covered person.



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### **CLASSES OF COVERED SERVICES AND SUPPLIES (Child Individuals up to Age 19)**

Coverage is provided for the dental services and supplies summarized below. For a complete list of covered services, please reference the listing at the end of this section.

Please note the age and frequency limitations that apply for certain procedures. All frequency limits specified are applied to the day.

For Your Policy, specific Covered Services and Supplies may fall under a Class category other than what is stated below. If Your Policy has Class categorizations different from below, it is specified on the Schedule of Benefits.

#### **Class I: Preventive Dental Services**

##### **Diagnostic and Preventive Benefits**

Benefit includes:

- Initial and periodic oral examinations
- Consultations, including specialist consultations
- Topical fluoride treatment
- Preventive dental education and oral hygiene instruction
- Radiographs (x-rays)
- Prophylaxis services (cleanings)
- Dental sealant treatments
- Space Maintainers, including removable acrylic and fixed band type
- Preventive dental education and oral hygiene instruction

### **Limitations**

- Exams are limited to one (1) in a six (6) consecutive month period – this does not apply to Emergency Treatment
- Bitewing x-rays in conjunction with periodic examinations are limited to one (1) series of four (4) films in any six (6) consecutive month period.
- Full mouth x-rays in conjunction with periodic examinations are limited to once every thirty-six (36) consecutive months
- Panoramic film x-rays are limited to once every thirty-six (36) consecutive months except when documented as essential for a follow-up/post-operative exam (such as after oral surgery).
- Prophylaxis services (cleanings) are limited to one (1) in a six (6) consecutive month period
- Fluoride treatments are limited to one (1) in a six (6) consecutive month period
- Dental sealant treatments are limited to permanent first and second molars only. Limited to once per tooth in a thirty-six (36) consecutive month period.

#### **Class II: Basic Dental Services**

##### **Restorative Dentistry**

Restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries
- Micro filled resin restorations which are non-cosmetic
- Replacement of a restoration
- Use of pins and pin build-up in conjunction with a restoration
- Sedative base and sedative fillings



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### Limitations

Restorations are limited to the following:

- For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations; any other restoration such as a crown or jacket is considered optional
- Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary. Limited to once per tooth in a twelve (12) consecutive month period.
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### Periodontal Maintenance

- Periodontal maintenance procedure (following active treatment). Benefit limited to one (1) periodontal maintenance procedure per three (3) consecutive month period.
- Periodontal maintenance procedures may be used in those cases in which a patient has completed active periodontal therapy. The procedure includes any examination for evaluation, curettage, root planing and/or polishing as may be necessary.

### Class III: Major Dental Services

#### Oral Surgery

Oral Surgery includes:

- Extractions, including surgical extractions
- Removal of impacted teeth
- Biopsy of oral tissues
- Alveolectomies
- Excision of cysts and neoplasms
- Treatment of palatal torus

- Treatment of mandibular torus
- Frenectomy
- Incision and drainage of abscesses
- Post-operative services, including exams, suture removal and treatment of complications
- Root recovery (separate procedure)

#### Limitation

- The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists

#### Endodontics

- Direct pulp capping
- Therapeutic pulpotomy
- Pulpal debridement
- Partial pulpotomy
- Pulpal therapy (both anterior and posterior)
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy, including culture canal and limited retreatment of previous root canal therapy as specified below
- Apicoectomy
- Vitality tests

#### Limitations

Root canal therapy, including culture canal, is limited as follows:

- Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms



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- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit

### ***Periodontics***

Periodontic benefits include:

- Emergency Treatment, including treatment for periodontal abscess and acute periodontitis
- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy
- Osseous or muco-gingival surgery

### **Limitation**

Periodontal scaling and root planing is limited to four (4) quadrant treatments in any twenty-four (24) consecutive months

### ***Crown and Fixed Bridge***

Crown and fixed bridge benefits include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel
- Related dowel pins and pin build-up
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold
- Recementation of crowns, bridges, inlays and onlays
- Cast post and core, including cast retention under crowns
- Repair or replacement of crowns, abutments or pontics

### **Limitations**

The crown benefit is limited as follows:

- Replacement of each unit is limited to once every sixty (60) consecutive months, except when the crown is no longer functional
- Only acrylic crowns and stainless steel crowns are a benefit for children under twelve (12) years of age. Limited to once per tooth in a twelve (12) consecutive month period. If other types of crowns are chosen as an optional benefit for children under twelve (12) years of age, the covered dental benefit level will be that of an acrylic crown
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling
- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown

The fixed bridge benefit is limited as follows:

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case.
  - If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person sixteen (16) years of age or older and the patient's oral health and general dental condition permits. For children under the age of sixteen (16), it is considered optional dental treatment. If performed on a Member under the age of sixteen (16), the applicant must pay the difference in cost between the fixed bridge and a space maintainer



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- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic
- Fixed bridges are optional when provided in connection with a partial denture on the same arch
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair
- The program allows up to five (5) units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment

### **Removable Prosthetics**

The removable prosthetics benefit includes:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers
- Office or laboratory relines or rebases
- Denture repair
- Denture adjustment
- Tissue conditioning
- Denture duplication
- Space Maintainer
- Stayplate

### **Limitations**

The removable prosthetics benefit is limited as follows:

- Partial dentures will not be replaced within sixty (60) consecutive months, unless:
  1. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; or

2. The denture is unsatisfactory and cannot be made satisfactory
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges
  - A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional
  - Full upper and/or lower dentures are not to be replaced within sixty (60) consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair
  - The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges
  - Office or laboratory relines are limited to one (1) per arch in any twelve (12) consecutive months
  - Tissue conditioning is limited to twice per denture in a thirty-six (36) consecutive month period
  - Stayplates are a benefit only when used as anterior space maintainers for children

### **Implants**

Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Prior authorization is required.



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### **Class IV: Medically Necessary Orthodontia**

#### **Orthodontics**

Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead. f. The automatic qualifying conditions are:

- i) cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
- ii) craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
- iii) a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
- iv) a crossbite of individual anterior teeth causing destruction of soft tissue,
- v) an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
- vi) a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the Policy.

Please see the list of covered procedures listed below in the CDT Code and Procedure Code Description listing.

### **Other Benefits**

Other dental benefits include:

- Local anesthetics
- Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Emergency Treatment, palliative treatment
- Coordination of benefits with Member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services

### **General Exclusions**

Covered Services and Supplies do not include:

1. Treatment which is:
  - a. not included in the list of Covered Services and Supplies except Medically Necessary Orthodontia;
  - b. not Dentally Necessary; or
  - c. Experimental in nature.
2. Any Charges which are:
  - a. Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, the Policy will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and Supplies.
  - b. Not imposed against the person or for which the person is not liable.
  - c. Reimbursable by Medicare Part A and Part B. If a person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her benefits under this Policy





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- will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law.
3. Services or supplies resulting from or in the course of Your regular occupation for pay or profit for which You or Your Dependent are paid benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and provide notification of all such benefits. Benefits paid under this Policy that are also paid under any Workers' Compensation Law, Employer's Liability Law or similar law may be recovered.
  4. Services or supplies provided by a Dentist, Dental Hygienist, dentist or doctor who is a Close Relative or a person who ordinarily resides with You or a Dependent.
  5. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The Covered Charge for the Services is based on the single dental procedure code that accurately represents the treatment performed.
  6. Services and supplies provided primarily for cosmetic purposes including bleaching/whitening.
  7. Services and supplies obtained while outside of the United States, except for Emergency Treatment.
  8. Diagnostic casts.
  9. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.
  10. Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
  11. Restorative procedures, root canals and appliances, which are provided because of attrition, abrasion, erosion, abfraction, wear, or for cosmetic purposes in the absence of decay.
  12. Veneers
  13. Appliances, inlays, cast restorations, crowns and bridges, or other laboratory prepared restorations used primarily for the purpose of splinting (temporary tooth stabilization).
  14. Replacement of a lost or stolen Appliance or Prosthesis.
  15. Replacement of stayplates.
  16. Extraction of pathology-free teeth, including supernumerary teeth (unless for medically necessary orthodontia)
  17. Socket preservation bone graphs
  18. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
  19. Treatment for a jaw fracture.
  20. Orthodontic services, supplies, appliances and Orthodontic-related services, unless an Orthodontic rider was included in the Policy.
  21. Oral sedation and nitrous oxide analgesia are covered only as described in the covered services section.
  22. Therapeutic drug injection.
  23. Charges for completion of claim forms.
  24. Missed dental appointments.
  25. The difference in cost between a covered service and an optional service. For instance, when an amalgam is an appropriate restorative treatment and a crown is opted instead. The amount of the benefit payment will be for the amalgam only.



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### **COVERED DENTAL PROCEDURES (Child Individuals up to Age 19)**

#### **CDT Code and Procedure Code Description**

##### **Diagnostic**

D0120 Periodic oral evaluation - established patient  
D0140 Limited oral evaluation – problem focused  
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver  
D0150 Comprehensive oral evaluation – new or established patient  
D0160 Detailed and extensive oral evaluation – problem focused, by report  
D0170 Re-evaluation – limited, problem focused (established patient; not postoperative visit)  
D0171 Re-evaluation – post-operative office visit  
D0180 Comprehensive periodontal evaluation – new or established patient  
D0210 Intraoral - complete series of radiographic images  
D0220 Intraoral - periapical first radiographic image  
D0230 Intraoral - periapical each additional radiographic image  
D0240 Intraoral - occlusal radiographic image  
D0250 Extraoral - first radiographic image  
D0251 Extraoral – posterior dental radiographic image  
D0270 Bitewing - single radiographic image  
D0272 Bitewings - two radiographic images  
D0273 Bitewings - three radiographic images  
D0274 Bitewings - four radiographic images  
D0277 Vertical bitewings - 7 to 8 radiographic images  
D0310 Sialography  
D0320 Temporomandibular joint arthrogram, including injection  
D0322 Tomographic survey  
D0330 Panoramic radiographic image  
D0340 Cephalometric radiographic image  
D0350 Oral/Facial photographic images  
D0351 3D photographic image

D0460 Pulp vitality tests  
D0470 Diagnostic casts  
D0502 Other oral pathology procedures, by report  
D0601 Caries risk assessment and documentation, with a finding of low risk  
D0602 Caries risk assessment and documentation, with a finding of moderate risk  
D0603 Caries risk assessment and documentation, with a finding of high risk  
D0999 Unspecified diagnostic procedure, by report

##### **Preventive**

D1110 Prophylaxis – adult  
D1120 Prophylaxis – child  
D1206 Topical application of fluoride varnish - child 0 to 20  
D1208 Topical application of fluoride - child 0-20  
D1310 Nutritional counseling for control of dental disease  
D1320 Tobacco counseling for the control and prevention of oral disease  
D1330 Oral hygiene instructions  
D1351 Sealant – per tooth  
D1352 Preventive resin restoration in a moderate to high caries risk patient - permanent tooth  
D1353 Sealant repair – per tooth  
D1354 Interim caries arresting medicament application – per tooth  
D1510 Space maintainer-fixed – unilateral  
D1520 Space maintainer-removable – unilateral  
D1550 Re-cementation of space maintainer  
D1555 Removal of fixed space maintainer  
D1575 Distal shoe space maintainer – fixed - unilateral

##### **Restorative**

D2140 Amalgam – one surface, primary or permanent  
D2150 Amalgam – two surfaces, primary or permanent  
D2160 Amalgam – three surfaces, primary or permanent  
D2161 Amalgam – four or more surfaces, primary or permanent



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D2330 Resin-based composite – one surface, anterior  
D2331 Resin-based composite – two surfaces, anterior  
D2332 Resin-based composite – three surfaces, anterior  
D2335 Resin-based composite – four or more surfaces or involving incisal angle (anterior)  
D2390 Resin-based composite crown, anterior  
D2391 Resin-based composite – one surface, posterior  
D2392 Resin-based composite – two surfaces, posterior  
D2393 Resin-based composite – three surfaces, posterior  
D2394 Resin-based composite – four or more surfaces, posterior  
D2710 Crown – resin - based composite (indirect)  
D2712 Crown - 3/4 resin-based composite (indirect)  
D2721 Crown – resin with predominantly base metal  
D2740 Crown – porcelain/ceramic substrate  
D2751 Crown – porcelain fused to predominantly base metal  
D2781 Crown – 3/4 cast predominantly base metal  
D2783 Crown – 3/4 porcelain/ceramic  
D2791 Crown – full cast predominantly base metal  
D2910 Recement inlay, onlay, or partial coverage restoration  
D2915 Recement cast or prefabricated post and core  
D2920 Recement crown  
D2921 Reattachment of tooth fragment, incisal edge or cusp  
D2929 Prefabricated porcelain/ceramic crown - primary tooth  
D2930 Prefabricated stainless steel crown – primary tooth  
D2931 Prefabricated stainless steel crown – permanent tooth  
D2932 Prefabricated resin crown  
D2933 Prefabricated stainless steel crown with resin window  
D2940 Protective restoration  
D2941 Interim therapeutic restoration – primary dentition  
D2949 Restorative foundation for an indirect restoration  
D2950 Core buildup, including any pins  
D2951 Pin retention – per tooth, in addition to restoration  
D2952 Post and core in addition to crown, indirectly fabricated  
D2953 Each additional indirectly fabricated post – same tooth

D2954 Prefabricated post and core in addition to crown  
D2955 Post removal  
D2957 Each additional prefabricated post -same tooth

D2971 Additional procedures to construct new crown under existing partial denture framework  
D2980 Crown repair, necessitated by restorative material failure  
D2999 Unspecified restorative procedure, by report

### **Endodontics**

D3110 Pulp cap – direct (excluding final restoration)  
D3120 Pulp cap – indirect (excluding final restoration)  
D3220 Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction application of medicament  
D3221 Pulpal debridement, primary and permanent teeth  
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development  
D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)  
D3240 Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)  
D3310 Endodontic therapy, anterior tooth (excluding final restoration)  
D3320 Endodontic therapy, bicuspid tooth (excluding final restoration)  
D3330 Endodontic therapy, molar tooth (excluding final restoration)  
D3331 Treatment of root canal obstruction; non-surgical access  
D3333 Internal root repair of perforation defects  
D3346 Retreatment of previous root canal therapy – anterior  
D3347 Retreatment of previous root canal therapy – bicuspid  
D3348 Retreatment of previous root canal therapy – molar  
D3351 Apexification/Recalcification/Pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection etc.)  
D3352 Apexification/Recalcification/Pulpal regeneration - interim medication replacement



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D3410 Apicoectomy/Periradicular surgery – anterior  
D3421 Apicoectomy/Periradicular surgery – bicuspid (first root)  
D3425 Apicoectomy/Periradicular surgery – molar (first root)  
D3426 Apicoectomy/Periradicular surgery – (each additional root)  
D3427 Periradicular surgery without apicoectomy  
D3430 Retrograde filling – per root  
D3910 Surgical procedure for isolation of tooth with rubber dam  
D3999 Unspecified endodontic procedure, by report

### Periodontics

D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bound spaces per quadrant  
D4211 Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant  
D4249 Clinical crown lengthening – hard tissue  
D4260 Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant  
D4261 Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces, per quadrant  
D4265 Biologic materials to aid in soft and osseous tissue regeneration  
D4341 Periodontal scaling and root planing – four or more teeth per quadrant  
D4342 Periodontal scaling and root planing – one to three teeth, per quadrant  
D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation  
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis  
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth  
D4910 Periodontal maintenance  
D4920 Unscheduled dressing change (by someone other than treating dentist)

D4999 Unspecified periodontal procedure, by report By Report

### Prosthodontics (Removable)

D5110 Complete denture – maxillary  
D5120 Complete denture – mandibular  
D5130 Immediate denture – maxillary  
D5140 Immediate denture – mandibular  
D5211 Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)  
D5212 Mandibular partial denture – resin base (including retentive/clasping materials, rest, and teeth)  
D5213 Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)  
D5214 Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)  
D5221 – Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)  
D5222 – Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)  
D5223 – Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)  
D5224 – Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)  
D5410 Adjust complete denture – maxillary  
D5411 Adjust complete denture – mandibular  
D5421 Adjust partial denture – maxillary  
D5422 Adjust partial denture – mandibular  
D5511 Repair broken complete denture base, mandibular  
D5512 Repair broken complete denture base, maxillary  
D5520 Replace missing or broken teeth – complete denture (each tooth)  
D5611 Repair resin denture base, mandibular  
D5612 Repair resin denture base, maxillary



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D5621 Repair cast framework, mandibular  
D5622 Repair cast framework, maxillary  
D5630 Repair or replace broken retentive/clasping materials per tooth  
D5640 Replace broken teeth – per tooth  
D5650 Add tooth to existing partial denture  
D5660 Add clasp to existing partial denture  
D5730 Reline complete maxillary denture (chairside)  
D5731 Reline complete mandibular denture (chairside)  
D5740 Reline maxillary partial denture (chairside)  
D5741 Reline mandibular partial denture (chairside)  
D5750 Reline complete maxillary denture (laboratory)  
D5751 Reline complete mandibular denture (laboratory)  
D5760 Reline maxillary partial denture (laboratory)  
D5761 Reline mandibular partial denture (laboratory)  
D5850 Tissue conditioning, maxillary  
D5851 Tissue conditioning, mandibular  
D5862 Precision attachment, by report  
D5863 Overdenture – complete maxillary  
D5864 Overdenture – partial maxillary  
D5865 Overdenture – complete mandibular  
D5866 Overdenture – partial mandibular  
D5899 Unspecified removable prosthodontic procedure, by report By Report

### **Maxillofacial Prosthetics**

D5911 Facial moulage (sectional)  
D5912 Facial moulage (complete)  
D5913 Nasal prosthesis  
D5914 Auricular prosthesis  
D5915 Orbital prosthesis  
D5916 Ocular prosthesis  
D5919 Facial prosthesis  
D5922 Nasal septal prosthesis

D5923 Ocular prosthesis, interim  
D5924 Cranial prosthesis  
D5925 Facial augmentation implant prosthesis  
D5926 Nasal prosthesis, replacement  
D5927 Auricular prosthesis, replacement  
D5928 Orbital prosthesis, replacement  
D5929 Facial prosthesis, replacement  
D5931 Obturator prosthesis, surgical  
D5932 Obturator prosthesis, definitive  
D5933 Obturator prosthesis, modification  
D5934 Mandibular resection prosthesis with guide flange  
D5935 Mandibular resection prosthesis without guide flange  
D5936 Obturator prosthesis, interim  
D5937 Trismus appliance (not for TMD treatment)  
D5951 Feeding aid  
D5952 Speech aid prosthesis, pediatric  
D5953 Speech aid prosthesis, adult  
D5954 Palatal augmentation prosthesis  
D5955 Palatal lift prosthesis, definitive  
D5958 Palatal lift prosthesis, interim  
D5959 Palatal lift prosthesis, modification  
D5960 Speech aid prosthesis, modification  
D5982 Surgical stent  
D5983 Radiation carrier  
D5984 Radiation shield  
D5985 Radiation cone locator  
D5986 Fluoride gel carrier  
D5987 Commissure splint  
D5988 Surgical splint  
D5991 Topical Medicament Carrier  
D5999 Unspecified maxillofacial prosthesis, by report

### **Implant Services**



## California Essential Health Benefit – PPO Family with EHB (for Children)

Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Prior authorization is required.

- D6010 Surgical placement of implant body: endosteal implant
- D6011 Second stage implant surgery
- D6013 Surgical placement of mini implant
- D6040 Surgical placement: eposteal implant
- D6050 Surgical placement: transosteal implant
- D6052 Semi-precision attachment abutment
- D6055 Connecting bar - implant supported or abutment supported
- D6056 Prefabricated abutment - includes modification and placement
- D6057 Custom fabricated abutment - includes placement
- D6058 Abutment supported porcelain/ceramic crown
- D6059 Abutment supported porcelain fused to metal crown (high noble metal)
- D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)
- D6061 Abutment supported porcelain fused to metal crown (noble metal)
- D6062 Abutment supported cast metal crown (high noble metal)
- D6063 Abutment supported cast metal crown (predominantly base metal)
- D6064 Abutment supported cast metal crown (noble metal)
- D6065 Implant supported porcelain/ceramic crown
- D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
- D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal)
- D6068 Abutment supported retainer for porcelain/ceramic FPD
- D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
- D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
- D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)
- D6072 Abutment supported retainer for cast metal FPD (high noble metal)

- D6073 Abutment supported retainer for cast metal FPD (predominantly base metal)
- D6074 Abutment supported retainer for cast metal FPD (noble metal)
- D6075 Implant supported retainer for ceramic FPD
- D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
- D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
- D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
- D6080 Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis
- D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
- D6085 Provisional implant crown
- D6090 Repair implant supported prosthesis, by report
- D6091 Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
- D6092 Recement implant/abutment supported crown
- D6093 Recement implant/abutment supported fixed partial denture
- D6094 Abutment supported crown (titanium)
- D6095 Repair implant abutment, by report
- D6096 Remove broken implant retaining screw
- D6100 Implant removal, by report
- D6110 Implant/abutment supported removable denture for edentulous arch – maxillary
- D6111 Implant/abutment supported removable denture for edentulous arch – mandibular
- D6112 Implant/abutment supported removable denture for partially edentulous arch – maxillary
- D6113 Implant/abutment supported removable denture for partially edentulous arch – mandibular



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D6114 Implant/abutment supported fixed denture for edentulous arch – maxillary  
D6115 Implant/abutment supported fixed denture for edentulous arch – mandibular  
D6116 Implant/abutment supported fixed denture for partially edentulous arch – maxillary  
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular  
D6190 Radiographic/Surgical implant index, by report  
D6194 Abutment supported retainer crown for FPD (titanium)  
D6199 Unspecified implant procedure, by report

### **Fixed Prosthodontics**

D6211 Pontic – cast predominantly base metal  
D6241 Pontic – porcelain fused to predominantly base metal  
D6245 Pontic –porcelain/ceramic  
D6251 Pontic – resin with predominantly base metal  
D6721 Crown – resin with predominantly base metal  
D6740 Crown – porcelain/ceramic  
D6751 Crown – porcelain fused to predominantly base metal  
D6781 Crown – 3/4 cast predominantly base metal  
D6783 Crown – 3/4 porcelain/ceramic  
D6791 Crown – full cast predominantly base metal  
D6930 Recement fixed partial denture  
D6980 Fixed partial denture repair, necessitated by restorative material failure  
D6999 Unspecified fixed prosthodontic procedure, by report

### **Oral and Maxillofacial Surgery**

D7111 Extraction, coronal remnants – deciduous tooth  
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

D7210 Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated  
D7220 Removal of impacted tooth – soft tissue  
D7230 Removal of impacted tooth – partially bony  
D7240 Removal of impacted tooth – completely bony  
D7241 Removal of impacted tooth – completely bony, with unusual surgical complications  
D7250 Surgical removal of residual tooth roots (cutting procedure)  
D7260 Oroantral fistula closure  
D7261 Primary closure of a sinus perforation  
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth  
D7280 Surgical access of an unerupted tooth  
D7283 Placement of device to facilitate eruption of impacted tooth  
D7285 Biopsy of oral tissue – hard (bone, tooth)  
D7286 Biopsy of oral tissue – soft  
D7290 Surgical repositioning of teeth  
D7291 Transseptal fiberotomy/supra crestal fiberotomy, by report  
D7310 Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant  
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant  
D7320 Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant  
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant  
D7340 Vestibuloplasty – ridge extension (secondary epithelialization)  
D7350 Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)  
D7410 Excision of benign lesion up to 1.25 cm  
D7411 Excision of benign lesion greater than 1.25 cm  
D7412 Excision of benign lesion, complicated



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- D7413 Excision of malignant lesion up to 1.25 cm
- D7414 Excision of malignant lesion greater than 1.25 cm
- D7415 Excision of malignant lesion, complicated
- D7440 Excision of malignant tumor – lesion diameter up to 1.25 cm
- D7441 Excision of malignant tumor – lesion diameter greater than 1.25 cm
- D7450 Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
- D7451 Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
- D7460 Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm
- D7461 Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm
- D7465 Destruction of lesion(s) by physical or chemical method, by report
- D7471 Removal of lateral exostosis (maxilla or mandible)
- D7472 Removal of torus palatinus
- D7473 Removal of torus mandibularis
- D7485 Surgical reduction of osseous tuberosity
- D7490 Radical resection of maxilla or mandible
- D7510 Incision and drainage of abscess – intraoral soft tissue
- D7511 Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
- D7520 Incision and drainage of abscess – extraoral soft tissue
- D7521 Incision and drainage of abscess - extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)
- D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
- D7540 Removal of reaction producing foreign bodies, musculoskeletal system
- D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone
- D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body
- D7610 Maxilla – open reduction (teeth immobilized, if present)
- D7620 Maxilla – closed reduction (teeth immobilized, if present)
- D7630 Mandible – open reduction (teeth immobilized, if present)
- D7640 Mandible – closed reduction (teeth immobilized, if present)
- D7650 Malar and/or zygomatic arch – open reduction
- D7660 Malar and/or zygomatic arch – closed reduction
- D7670 Alveolus – closed reduction, may include stabilization of teeth
- D7671 Alveolus – open reduction, may include stabilization of teeth
- D7680 Facial bones – complicated reduction with fixation and multiple surgical approaches
- D7710 Maxilla – open reduction
- D7720 Maxilla – closed reduction
- D7730 Mandible – open reduction
- D7740 Mandible – closed reduction
- D7750 Malar and/or zygomatic arch – open reduction
- D7760 Malar and/or zygomatic arch – closed reduction
- D7770 Alveolus – open reduction stabilization of teeth
- D7771 Alveolus, closed reduction stabilization of teeth
- D7780 Facial bones – complicated reduction with fixation and multiple surgical approaches
- D7810 Open reduction of dislocation
- D7820 Closed reduction of dislocation
- D7830 Manipulation under anesthesia
- D7840 Condylectomy
- D7850 Surgical discectomy, with/without implant
- D7852 Disc repair
- D7854 Synovectomy
- D7856 Myotomy
- D7858 Joint reconstruction
- D7860 Arthroscopy
- D7865 Arthroplasty
- D7870 Arthrocentesis
- D7871 Non-arthroscopic lysis and lavage
- D7872 Arthroscopy – diagnosis, with or without biopsy
- D7873 Arthroscopy – surgical: lavage and lysis of adhesions
- D7874 Arthroscopy – surgical: disc repositioning and stabilization
- D7875 Arthroscopy – surgical: synovectomy





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D7876 Arthroscopy – surgical: discectomy  
D7877 Arthroscopy – surgical: debridement  
D7880 Occlusal orthotic device, by report D7881 Occlusal orthotic device adjustment  
D7881 Occlusal orthotic device adjustment  
D7899 Unspecified TMD therapy, by report  
D7910 Suture of recent small wounds up to 5 cm  
D7911 Complicated suture – up to 5 cm  
D7912 Complicated suture – greater than 5 cm  
D7920 Skin graft (identify defect covered, location and type of graft)  
D7940 Osteoplasty – for orthognathic deformities  
D7941 Osteotomy – mandibular rami  
D7943 Osteotomy – mandibular rami with bone graft; includes obtaining the graft  
D7944 Osteotomy – segmented or subapical  
D7945 Osteotomy – body of mandible  
D7946 LeFort I (maxilla – total)  
D7947 LeFort I (maxilla – segmented)  
D7948 LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft  
D7949 LeFort II or LeFort III – with bone graft  
D7950 Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report  
D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach  
D7952 Sinus augmentation with bone or bone substitute via a vertical approach  
D7955 Repair of maxillofacial soft and/or hard tissue defect  
D7960 Frenulectomy also known as frenectomy or frenotomy – separate procedure not incidental to another procedure  
D7963 Frenuloplasty  
D7970 Excision of hyperplastic tissue – per arch  
D7971 Excision of pericoronal gingiva  
D7972 Surgical reduction of fibrous tuberosity

D7979 Non-surgical Sialolithotomy  
D7980 Sialolithotomy  
D7981 Excision of salivary gland, by report  
D7982 Sialodochoplasty  
D7983 Closure of salivary fistula  
D7990 Emergency tracheotomy  
D7991 Coronoidectomy  
D7995 Synthetic graft – mandible or facial bones, by report  
D7997 Appliance removal (not by dentist who placed appliance), includes removal of archbar  
D7999 Unspecified oral surgery procedure, by report

### **Orthodontics**

D8080 Comprehensive orthodontic treatment of the adolescent dentition  
D8210 Removable appliance therapy  
D8220 Fixed appliance therapy  
D8660 Pre-orthodontic treatment visit  
D8670 Periodic orthodontic treatment visit (as part of contract)  
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))  
D8681 Removable orthodontic retainer adjustment  
D8691 Repair of orthodontic appliance  
D8692 Replacement of lost or broken retainer  
D8693 Rebonding or recementing: and/or repair, as required, of fixed retainers  
D8694 Repair of fixed retainers, includes reattachment  
D8999 Unspecified orthodontic procedure, by report

### **Adjunctives**

D9110 Palliative (emergency) treatment of dental pain – minor procedure  
D9120 Fixed partial denture sectioning  
D9210 Local anesthesia not in conjunction with operative or surgical procedures



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D9211 Regional block anesthesia  
D9212 Trigeminal division block anesthesia  
D9215 Local anesthesia in conjunction with operative or surgical procedures  
D9222 Deep sedation/analgesia – first 15 minute  
D9223 Deep sedation/general anesthesia – each 15 minute increment  
D9230 Inhalation of nitrous oxide/anxiolysis analgesia  
D9239 Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes  
D9243 Intravenous conscious sedation/analgesia – each 15 minute increment  
D9248 Non-intravenous conscious sedation  
D9310 Consultation diagnostic service provided by dentist or physician other than requesting dentist or physician  
D9311 Consultation with a medical health professional  
D9410 House/Extended care facility call  
D9420 Hospital or ambulatory surgical center call  
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed  
D9440 Office visit – after regularly scheduled hours  
D9610 Therapeutic parenteral drug, single administration  
D9612 Therapeutic parenteral drug, two or more administrations, different medications  
D9910 Application of desensitizing medicament  
D9930 Treatment of complications (post-surgical) – unusual circumstances, by report  
D9950 Occlusion analysis – mounted case  
D9951 Occlusal adjustment – limited  
D9952 Occlusal adjustment – complete  
D9999 Unspecified adjunctive procedure, by report



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### **CLASSES OF COVERED SERVICES AND SUPPLIES (Adult Individuals age 19 and over)**

Coverage is provided for the dental services and supplies described in this section.

Please note the age and frequency limitations that apply for certain procedures. All frequency limits specified are applied to the day.

For Your Policy, specific Covered Services and Supplies may fall under a Class category other than what is stated below. If Your Policy has Class categorizations different from below, it is specified on the Schedule of Benefits.

#### **Class I: Preventive Dental Services**

- Comprehensive exams, periodic exams, evaluations, re-evaluations, limited oral exams, or periodontal evaluations. Limited to 1 per 6 month period, except for Emergency Treatment.
- Dental prophylaxis (cleaning and scaling). Benefit limited to either 1 dental prophylaxis or 1 periodontal maintenance procedure per 6 month period, but not both.
- Topical fluoride treatment.
  - Limited to one per 6 month period.
- Palliative (emergency) treatment of dental pain
  - Considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered during the same visit.
- Sealant applications are limited to one per 36 month period, on un-restored pit and fissures of a 1<sup>st</sup> and 2<sup>nd</sup> permanent molar.
- X-rays:
  - Intraoral complete series x-rays, including bitewings and 10 to

14 periapical x-rays, or panoramic film. Limited to one per 60 month period. Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a calendar year.

- Bitewing x-rays (two or four films). Limited to one per 12 month period. Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a calendar year.
- Other X-rays:
  - Intraoral periapical x-rays.
  - Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a calendar year.
  - Intraoral occlusal x-rays, limited to one film per arch per 6 month period.
  - Extraoral x-rays, limited to one film per 6 month period.
  - Other x-rays (except films related to orthodontic procedures or temporomandibular joint dysfunction).
- Space maintainers, including all adjustments made within 6 months of installation.

#### **Class II: Basic Dental Services**

- Amalgam and composite restorations, limited as follows:
  - Multiple restorations on one surface will be considered a single filling.
  - Multiple restorations on different surfaces of the same tooth will be considered connected.



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- Benefits for replacement of an existing restoration will only be considered for payment if at least 36 months have passed since the existing restoration was placed (except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy).
- Additional fillings on the same surface of a tooth in less than 36 months, by the same office or same Dentist are not covered, except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy.
- Sedative bases and liners are considered part of the restorative service and are not paid as separate procedures.
- Composite restorations are also limited as follows:
  - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial restorations on anterior teeth will be considered single surface restorations
  - Acid etch is not covered as a separate procedure
  - Benefits limited to anterior teeth only.
  - Benefits for composite resin restorations on posterior teeth are limited to the benefit for the corresponding amalgam restoration.
- Pins, in conjunction with a final amalgam restoration
- Stainless steel crowns, limited to one per 36 month period for teeth not restorable by an amalgam or composite filling.
- Periodontal maintenance procedure (following active treatment). Benefit limited to either 1 periodontal maintenance procedure or 1 dental prophylaxis per 6 month period, but not both.
- Periodontal maintenance procedures may be used in those cases in which a patient has completed active periodontal therapy, and commencing no sooner than 3 months thereafter. The procedure includes any examination for evaluation, curettage, root planing and/or

polishing as may be necessary.

- Consultation, including specialist consultations, limited as follows:
  - Considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered on the same date.
  - Benefits will not be considered for payment if the purpose of the consultation is to describe the Dental Treatment Plan.

### **Class III: Major Dental Services**

- Inlays and onlays (metallic), limited as follows:
  - Covered only when the tooth cannot be restored by an amalgam or composite filling.
  - Covered only if more than 5 years have elapsed since last placement.
  - Build-up procedure is considered covered and is inclusive in the fee.
  - Benefits are based on the date of cementation.
- Porcelain restorations on anterior teeth, limited as follows:
  - Covered only when the tooth cannot be restored by an amalgam or composite filling.
  - Covered only if more than 5 years have elapsed since last placement.
  - Limited to permanent teeth. Porcelain restorations on over-retained primary teeth are not covered.
  - Build-up procedure is considered covered and is inclusive in the fee.
  - Benefits are based on the date of cementation.
- Cast crowns, limited as follows:
  - Covered only when the tooth cannot be restored by an amalgam or composite filling.



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- Covered only if more than 5 years have elapsed since last placement.
- Limited to permanent teeth. Cast crowns on over-retained primary teeth are not covered.
- Crowns on third molars are covered when adjacent first or second molars are missing and the tooth is in function with an opposing natural tooth.
- Build-up procedure is considered covered and inclusive in the fee.
- Benefits are based on the date of cementation.
- Crown lengthening is limited to a single site when contiguous teeth are involved.
- Re-cementing inlays, crowns and bridges are limited to three per tooth, 12 months after last cementation.
- Post and core:
  - Covered only for endodontically- treated teeth, which require crowns.
  - 1 post and core is covered per tooth.
- Full dentures, limited as follows:
  - Limited to 1 full denture per arch.
  - Replacement covered only if 5 years have elapsed since last replacement AND the full denture cannot be made serviceable (please refer to the Denture or Bridge Replacement/Addition provision under Exclusions and Limitations for exceptions).
  - Services include any adjustments or relines which are performed within 12 month of initial insertion.
  - We will not pay additional benefits for personalized dentures or overdentures or associated treatment.
  - Benefits for dentures are based on the date of delivery.
- Partial dentures, including any clasps and rests and all teeth, limited as follows:
  - Limited to one partial denture per arch.
  - Replacement covered only if 5 years have elapsed since last placement AND the partial denture cannot be made serviceable (please refer to the denture or bridge replacement/addition provision under exclusions and limitations for exceptions).
  - Services include any adjustments or relines which are performed within 12 months of initial insertion.
  - There are no benefits for precision or semi-precision attachments.
  - Benefits for partial dentures are based on the date of delivery.
- Denture adjustments are limited to:
  - One time in any 12 month period; and
  - Adjustments made more than 12 months after the insertion of the denture.
- Repairs to full or partial dentures, bridges, and crowns are limited to repairs or adjustments performed up to 3 times after the initial insertion.
- Rebasing dentures are limited to one time per 12 month period.
- Relining dentures is a covered benefit 12 months after initial insertion of the denture.
  - Limited to one time per 12 month period
- Tissue conditioning is limited to one time in a 12 month period.
- Fixed bridges (including Maryland bridges) are limited as follows:
  - Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge:
    - Is more than 5 years old (see the Denture or Bridge Replacement/Addition provision under Exclusions and Limitations for exceptions); and
    - Cannot be made serviceable.
  - A fixed bridge replacing the extracted portion of a hemisected



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- tooth is not covered.
- Placement and replacement of a cantilever bridge on posterior teeth will not be covered.
- Benefits for bridges are based on the date of cementation.
- Re-cementing bridges is limited to repairs or adjustment performed more than 12 months after the initial insertion.
- Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care:
  - Simple extractions
  - Surgical extractions, including extraction of third molars with pathology (wisdom teeth)
  - Alveoplasty
  - Vestibuloplasty
  - Removal of exostoses (including tori) – maxilla or mandible
  - Frenulectomy (frenectomy or frenotomy)
  - Excision of hyperplastic tissue – per arch
- Tooth re-implantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus, limited to permanent teeth only.
- Root removal – exposed roots.
- Biopsy
- Incision and drainage
- The most inclusive procedure will be considered for payment when two or more surgical procedures are performed.
- Pulpotomy (primary teeth only).
- Root canal therapy:
  - Including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia, all irrigants, obstruction of root canals and routine follow-up care
  - Limited to one time on the same tooth per 24 month period by the same provider.
  - Limited to permanent teeth only.
- Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), including all preoperative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Retrograde filling - per root.
- Root amputation - per root.
- Hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care does not include a benefit for root canal therapy.
- Periodontal scaling and root planing, limited as follows:
  - 4 or more teeth per quadrant, limited to a minimum of 5mm pockets (per tooth), with radiographic evidence of bone loss, covered 1 time per quadrant per 24 month period.
  - 1 to 3 teeth per quadrant, limited to minimum of 5mm pockets (per tooth), with radiographic evidence of bone loss, covered 1 time per area per 24 month period.
  - Under unusual circumstances, additional documentation can be submitted for review.
  - Following osseous surgery root planing is a benefit after 36 months in the same area.
- Periodontal related services as listed below, limited to one time per quadrant of the mouth in any 36 month period with charges combined for procedures as listed below:
  - Gingival flap procedures.
  - Gingivectomy procedures.
  - Osseous surgery.
  - Pedicle tissue grafts.



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- Soft tissue grafts.
- Subepithelial tissue grafts.
- Bone replacement grafts.
- Guided tissue regeneration.
- Crown lengthening procedures - hard tissue.
- The most inclusive procedure will be considered for payment when 2 or more surgical procedures are performed.
- General anesthesia and intravenous sedation, limited as follows:
  - Considered for payment as a separate benefit only when medically necessary and when administered in the Dentist's office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the Policy.
  - Not a benefit for the management of fear and anxiety;
  - Oral sedation is not a covered benefit.

### EXCLUSIONS AND LIMITATIONS

#### Treatment Outside of the Covered Service Area

Treatment outside of your covered state and/or United States is not covered, unless the treatment is for Emergency Treatment.

#### Missing Teeth Limitation

A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Policy. For the first 24 months of coverage, a full denture, partial denture or fixed bridge will not be covered when replacing a tooth or teeth lost or extracted before being covered under this Policy.

#### Denture or Bridge Replacement/Addition

- Replacement of a full denture, partial denture, or fixed bridge is covered when:
  - 5 years have elapsed since last replacement of the denture or bridge; OR
  - The denture or bridge was damaged while in the Covered Person's mouth when an injury was suffered involving external, violent and accidental means. The injury must have occurred while insured under this Policy, and the appliance cannot be made serviceable.

However, the following exceptions will apply:

- Benefits for the replacement of an existing partial denture that is less than 5 years old will be covered if there is a Dentally Necessary extraction of an additional Functioning Natural Tooth that cannot be added to the existing partial denture.
- Benefits for the replacement of an existing fixed bridge that is less than 5 years old will be payable if there is a Dentally Necessary extraction of an additional Functioning Natural Tooth, and the extracted tooth was not an abutment to an existing bridge.
- Replacement of a lost bridge is not a Covered Benefit.
- A bridge to replace extracted roots when the majority of the natural crown is missing is not a Covered Benefit.
- Replacement of an extracted tooth will not be considered a Covered Benefit if the tooth was an abutment of an existing Prosthesis that is less than 5 years old.
- Replacement of an existing partial denture, full denture, crown or



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bridge with more costly units/different type of units is limited to the corresponding benefit for the existing unit being replaced.

### Implants

Implants, and procedures and appliances associated with them, are not covered.

### General Exclusions

Covered Services and Supplies do not include:

1. Treatment which is:
  - a. not included in the list of Covered Services and Supplies;
  - b. not Dentally Necessary; or
  - c. Experimental in nature.
2. Any Charges which are:
  - d. Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, the Policy will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and Supplies.
  - e. Not imposed against the person or for which the person is not liable.
  - f. Reimbursable by Medicare Part A and Part B. If a person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her benefits under this Policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law.
3. Services or supplies resulting from or in the course of Your regular occupation for pay or profit for which You or Your Dependent are paid under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and provide notification of all such benefits. Benefits paid under this Policy that are also paid under

- any Workers' Compensation Law, Employer's Liability Law or similar law may be recovered.
4. Services or supplies provided by a Dentist, Dental Hygienist, denturist or doctor who is a Close Relative or a person who ordinarily resides with You or a Dependent.
5. Services and supplies which may not reasonably be expected to successfully correct the Covered Person's dental condition for a period of at least 3 years.
6. All services for which a claim is received more than 6 months after the date of service.
7. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The Covered Charge for the Services is based on the single dental procedure code that accurately represents the treatment performed.
8. Services and supplies provided primarily for cosmetic purposes, including bleaching/whitening.
9. Services and supplies obtained while outside of the United States, except for Emergency Treatment.
10. Correction of congenital conditions or replacement of congenitally missing permanent teeth, regardless of the length of time the deciduous tooth is retained.
11. Diagnostic casts.
12. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.
13. Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
14. Restorative procedures, root canals and appliances, which are provided because of attrition, abrasion, erosion, abfraction, wear, or for cosmetic purposes in the absence of decay.
15. Veneers.
16. Appliances, inlays, cast restorations, crowns and bridges, or other laboratory prepared restorations used primarily for the purpose of





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- splinting (temporary tooth stabilization).
17. Replacement of a lost or stolen Appliance or Prosthesis.
  18. Replacement of stayplates.
  19. Extraction of pathology-free teeth, including supernumerary teeth.
  20. Socket preservation bone graphs.
  21. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
  22. Treatment for a jaw fracture.
  23. Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the Policy.
  24. Non- Medically Necessary Orthodontic services, supplies, appliances and Orthodontic-related services.
  25. Oral sedation and nitrous oxide analgesia are not covered.
  26. Therapeutic drug injection.
  27. Charges for the completion of claim forms.
  28. Missed dental appointments.
  29. Replacement of missing teeth prior to coverage effective date.

## Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

### Discrimination is Against the Law

Premier Access Insurance Company, a wholly owned subsidiary of Guardian Life Insurance Company of America, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Guardian and its subsidiaries does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Premier Access Insurance Company provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters; written information in other formats (large print, audio, accessible electronic formats); and 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, call 1-844-561-5600.

If you believe that Guardian or its subsidiaries 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 with:

Premier Access Civil Rights Coordinator  
ATTN: Manager Compliance Metrics, Corporate Compliance  
Guardian Life Insurance Company of America  
7 Hanover Square - 23F  
New York, New York 10004

212-919-3162

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Premier Access's Civil Rights Coordinator 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, D.C. 20201  
1-800-368-1019  
1-800-537-7697 (TDD)

Complaint forms are available at:

<http://www.hhs.gov/ocr/office/file/index.html>



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 Member Services (TTD/TTY 7-1-1). The Guardian, and its subsidiaries\*, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

**SPANISH** – Servicios de idiomas sin costo. Puedes obtener un intérprete. Puede obtener documentos leídos y algunos enviados a usted en su idioma. Para obtener ayuda, llame a Servicios para Miembros. The Guardian y sus subsidiarias \* cumplen con las leyes federales de derechos civiles aplicables y no discriminan por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

**ARMENIAN** - Չկան ծախսերի լեզուների ծառայություններ: Դուք կարող եք ստանալ թարգմանիչ: Դուք կարող եք ստանալ փաստաթղթեր կարդալու ձեզ եւ ունեւք ձեր լեզվով ուղարկված են: Օգնության համար զանգահարեք Անդամների ծառայություններ: The Guardian - ք եւ նրա դուստր ձեռնարկությունները համապատասխանում են դաշնային քաղաքացիական իրավունքի մասին օրենքներին եւ չեն խտրում ռասայի, գույնի, ազգային ծագման, տարիքի, հաշմանդամության կամ սեռի հիման վրա:

**ARABIC** - لقوانين له التابعة والفروع الوصي ويمتثل. الأعضاء بخدمات اتصل ، تعليمات علي للحصول. لغتك في لك أرسلت والبعض لك تقرا وثائق علي الحصول يمكنك. مترجم علي الحصول. الجنس أو إعاقه أو السن أو القومي الأصل أو اللون أو العرق أساس علي يميز ولا السارية الاتحادية المدنية الحقوق.

**BENGALI** - কোনো কস্ট ল্যাঙ্গুয়েজ সার্ভিস নেই। দোভাষী পেতে পারেন। আপনি আপনার কাছে আপনার কাছে পাঠানো নথিপত্র পেতে পারেন এবং আপনার ভাষায় কিছু পাঠিয়েছেন। সাহায্যের জন্য, কল মেম্বার সার্ভিস। "গার্ডিয়ান" এবং এর সাবসিডিয়ারি \* প্রযোজ্য ফেডারেল নাগরিক অধিকার আইন এবং জাতি, রঙ, জাতীয় উৎপত্তি, বয়স, অক্ষমতা, বা লিঙ্গের ভিত্তিতে বৈষম্যমূলক ব্যবহার করে না।

**CAMBODIAN** - មិនមានសេវាកម្មភាសាឥតគិតថ្លៃទេ។ អ្នកអាចទទួលបានអ្នកបកប្រែ។ អ្នកអាចអានឯកសារដែលអ្នកបានអានហើយខ្លះឆ្លើយទៅអ្នកជាការសរសេរអ្នក។ សំរាប់ជំនួយសូមហៅទូរស័ព្ទទៅសេវាកម្មសមាជិក។ "អាណាញ៉ាបាល" នឹងក្រុមហ៊ុនបុត្រសង្គ័ន្ធ \* របស់ការពារកម្ពុជាសិទ្ធិស៊ីវិលរបស់សហព័ទ្ធហើយមិនរើសអើងលើមូលដ្ឋានពូជសាសន៍ពណ៌សម្បុរដើមកំណើតអាយុពិការភាពឬការរួមគ្នាឡើយ។

**CHINESE** - 无成本语言服务。你可以找个翻译。您可以将文档读给您,有些则用您的语言发送给您。有关帮助,请致电会员服务。监护人及其附属公司 \* 遵守适用的联邦民权法,不因种族、肤色、国籍、年龄、残疾或性别而受到歧视。

**FRENCH** - Aucun coût des services linguistiques. Vous pouvez obtenir un interprète. Vous pouvez obtenir des documents lus pour vous et certains qui vous sont envoyés dans votre langue. Pour de l'aide, appelez les services aux membres. The Guardian et ses filiales \* respectent les lois fédérales applicables en matière de droits civiques et ne discriminent pas sur la base de la race, de la couleur, de l'origine nationale, de l'âge, du handicap ou du sexe.

**GERMAN** - Keine Kosten Sprachdienstleistungen. Sie können einen Dolmetscher bekommen. Sie können Dokumente lesen, um Sie und einige an Sie in ihrer Sprache. Rufen Sie die Mitglieder Dienste auf, um Hilfe zu leisten. Der Guardian und seine Tochtergesellschaften \* entsprechen den geltenden Bundes bürgerlichen Rechtsvorschriften und diskriminieren nicht auf der Grundlage von Rasse, Farbe, nationaler Herkunft, Alter, Behinderung oder Geschlecht.

**HAITIAN-CREOLE** - Pa gen sèvis konbinazon lang. Ou ka jwenn yon entèprèt. Ou ka jwenn dokiman li pou ou ak kèk voye pou nou nan lang ou. Pou èd, rele sèvis manb. The Guardian, epi li filiales \* soumèt li a aplikab lwa Federal dwa sivil pa diskrimine sou baz ras, koulè, orijin nasyonal, laj, enfimite, oubyen sèks

**HINDI** - कोई लागत भाषा सेवाएं। तुम एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ आप को पढ़ने के लिए और कुछ अपनी भाषा में आप के लिए भेजा प्राप्त कर सकते हैं। मदद के लिए, सदस्य सेवाएं कॉल करें। द गार्जियन और उसकी सहायक कंपनियां \* लागू संघीय नागरिक अधिकार कानूनों का अनुपालन करती हैं और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता या सेक्स के आधार पर भेदभाव नहीं करतीं।

**HMONG** - Tsis muaj nqi lus pab. Koj yuav tau ib tug neeg txhais lus. Koj yuav tau txais tej ntaub ntauv nyeem rau koj thiab ib co rau koj xa koj cov lus. Pab, hu rau Member Services. The Guardian thiab nws cov subsidiaries \* raws li muaj txog neeg txoj cai tsoom fww teb chaws thiab cais ib haiv neeg, xim, keeb kwm teb chaws, hnuv nyoog, mob xiam oob qhab los yog pw ua ke.

<p><b>ITALIAN</b> – Servizi linguistici senza costi. È possibile ottenere un interprete. È possibile ottenere documenti letti a voi e alcuni inviati a voi nella vostra lingua. Per assistenza, chiamare i servizi membri. The Guardian e le sue filiali * sono conformi alle leggi federali vigenti in materia di diritti civili e non discriminano sulla base di razza, colore, origine nazionale, età, invalidità o sesso.</p>
<p><b>JAPANESE</b> - 無償の言語サービスはありません。通訳を受けることができます。あなたは、あなたとあなたの言語で送信されたいいくつかのドキュメントを読んで得ることができます。ヘルプについては、メンバーサービスと呼び出します。ガーディアンとその子会社 * 適用される連邦民事権法に準拠し、人種、色、国の起源、年齢、障害、または性別に基づいて差別していません。</p>
<p><b>KOREAN</b> -비용 언어 서비스 없음. 통역을 받을 수 있습니다. 당신은 문서를 당신에 게 읽어 얻을 수 있으며 일부는 귀하의 언어로 보냈습니다. 도움말을 위해 멤버 서비스를 호출 합니다. 후견인 및 그것의 자회사 *는 적용 가능한 연방 시민권 법률에 따르고 인종, 색깔, 국가 근원, 나이, 무력, 또는 성을 기준으로 하여 감 별 하지 않는다.</p>
<p><b>NAVAHO</b> - Dii baa ako ninizin: Dii saad bee yanilti go Dine Bizaad, saad bee aka anida awo dee, t’aa jiik’eg.</p>
<p><b>PUNJABI</b> - ਕੋਈ ਲਾਗਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਨਹੀਂ ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ ਤੁਸੀਂ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਸਕਦੇ ਹੋ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿਚ ਤੁਹਾਨੂੰ ਭੇਜੀ ਜਾ ਸਕਦੀ ਹੈ. ਸਹਾਇਤਾ ਲਈ, ਸਟੱਸ ਸੇਵਾਵਾਂ ਨੂੰ ਕਾਲ ਕਰੋ "ਗਾਰਡੀਅਨ" ਅਤੇ ਇਸ ਦੀਆਂ ਸਹਾਇਕ ਕੰਪਨੀਆਂ ਲਾਗੂ ਹੋਣ ਵਾਲੇ ਸੰਖੀ ਸਹਿਰੀ ਅਧਿਕਾਰਾਂ ਦੇ ਕਾਨੂੰਨਾਂ ਦੀ ਪਾਲਣਾ ਕਰਦੀਆਂ ਹਨ ਅਤੇ ਨਸਲ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਪੰਗਤਾ ਜਾਂ ਲਿੰਗ ਦੇ ਆਧਾਰ ਤੇ ਵਿਤਕਰਾ ਨਹੀਂ ਕਰਦੀਆਂ</p>
<p><b>RUSSIAN</b> - Нет затрат языковых услуг. Вы можете получить переводчика. Вы можете получить документы, прочитанные вам и некоторые послал к вам на вашем языке. Для справки позвоните в службу участников. The Guardian и его дочерние компании * соответствуют действующим федеральным законам о гражданских правах и не допускают дискриминации по признаку расы, цвета кожи, национального происхождения, возраста, инвалидности или пола.</p>
<p><b>POLISH</b> – Usługi językowe bez kosztów. Można uzyskać tłumacza. Możesz pobrać dokumenty do Ciebie, a niektóre wysyłane do Ciebie w swoim języku. Aby uzyskać pomoc, należy wywołać usługi członkowskie. The Guardian " i jego spółki zależne * są zgodne z obowiązującymi przepisami prawa federalnego w zakresie praw obywatelskich i nie dyskryminuje ze względu na rasę, kolor, pochodzenie narodowe, wiek, niepełnosprawność lub płeć.</p>
<p><b>PORTUGUESE</b> - Nenhum serviço de linguagem de custo. Pode arranjar um intérprete. Você pode obter documentos lidos para você e alguns enviados para você em seu idioma. Para ajudar, ligue para os serviços de membros. The Guardian e suas subsidiárias * cumprem as leis federais aplicáveis aos direitos civis e não discriminam com base na raça, cor, origem nacional, idade, incapacidade ou sexo.</p>
<p><b>SERBO-CROATION</b> – Nema troškova jezičke usluge. Možete dobiti prevodioca. Možete dobiti dokumente čitati te i neke vama poslati na vašem jeziku. Za pomoć, zovi usluge za članstvo. The Guardian i njene podružnice * u skladu sa federalnom građanska prava je primenjivan i ne diskriminira na osnovu rase, boje, nacionalnog porekla, godinama, invaliditeta ili seksa.</p>
<p><b>SYRIAC</b> - ܡܢܝܡܐ ܘܢܘܠܝܢ ܟܘܢܘܢܐ ܠܘܫܘܢܐ ܘܠܘܥܘܠܐ. ܡܢܝܢܝܢ ܠܠܚܘܢܐ ܠܠܘܫܘܢܐ ܘܠܠܘܥܘܠܐ. ܡܢܝܢܝܢ ܠܠܚܘܢܐ ܠܠܘܫܘܢܐ ܘܠܠܘܥܘܠܐ. ܡܢܝܢܝܢ ܠܠܚܘܢܐ ܠܠܘܫܘܢܐ ܘܠܠܘܥܘܠܐ. ܡܢܝܢܝܢ ܠܠܚܘܢܐ ܠܠܘܫܘܢܐ ܘܠܠܘܥܘܠܐ. ܡܢܝܢܝܢ ܠܠܚܘܢܐ ܠܠܘܫܘܢܐ ܘܠܠܘܥܘܠܐ. ܡܢܝܢܝܢ ܠܠܚܘܢܐ ܠܠܘܫܘܢܐ ܘܠܠܘܥܘܠܐ. ܡܢܝܢܝܢ ܠܠܚܘܢܐ ܠܠܘܫܘܢܐ ܘܠܠܘܥܘܠܐ.</p>
<p><b>TAGALOG</b> – Walang mga serbisyo sa gastos ng wika. Maaari kang makakuha ng interpreter. Maaari kang makakuha ng mga dokumento na basahin sa iyo at sa ilan ay nagpadala sa iyo sa iyong wika. Para sa tulong, tawagan ang serbisyo para sa miyembro. "The Guardian" at subsidyaryo nito * sumunod sa naaangkop na pederal batas sa karapatang sibil at hindi nagtatangi batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan, o kasarian.</p>
<p><b>THAI</b> - ไม่มีการคิดค่าบริการ ทุนจะได้รับการสนับสนุนจากรัฐบาลกลางและไม่ได้รับค่าตอบแทนตามพื้นฐานของการแข่งขันที่ยุติธรรมหากเกิดความพิการหรือเพศ เป็นไปตามกฎหมายว่าด้วยสิทธิมนุษยชนของรัฐบาลกลางและไม่ได้รับค่าตอบแทนตามพื้นฐานของการแข่งขันที่ยุติธรรมหากเกิดความพิการหรือเพศ</p>
<p><b>VIETNAMESE</b> - Không có ngôn ngữ chi phí dịch vụ. Bạn có thể nhận được một thông dịch viên. Bạn có thể nhận được tài liệu đọc bạn và một số được gửi đến cho bạn bằng ngôn ngữ của bạn. Để được trợ giúp, hãy gọi Dịch vụ hội viên. "The Guardian" và công ty con của nó * tuân thủ các luật liên bang quyền dân sự và không phân biệt đối xử trên cơ sở chủng tộc, màu sắc, nguồn gốc quốc gia, tuổi, người khuyết tật hoặc quan hệ tình dục.</p>

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