



## Texas Essential Health Benefit – Premier Choice Family Plan with EHB (for Children)

This summary of benefits, along with the exclusions and limitations describe the benefits of the Essential Health Benefit – Premier Choice Family Plan with EHB (for Children). Please review closely to understand all benefits, exclusions and limitations.

Child-ONLY* Essential Health Benefit	In-Network	Out-of- Network**
<b>Class I/Preventive</b> - Cleanings, Exams, Fluoride, Sealants, Space Maintainers, Emergency Pain and Radiographs-Bitewings.	100%	100%
<b>Class II/Basic</b> - Radiographs (Full Mouth X-ray, Panoramic Film) Restorations (Amalgams and Anterior Resins), Simple Extractions and Anesthesia (General Anesthesia and Intravenous Sedation).	80%	80%
<b>Class III/Major</b> - Surgical Extractions, Oral Surgery, Endodontics, Periodontal Maintenance, Periodontics, Inlay, Onlays, Crowns, Crown Repair, Bridges, Bridge Repairs, Dentures and Denture Repair.	50%	50%
<b>Class II, III and IV/Orthodontia</b> (Only for pre-authorized Medically Necessary Orthodontia)	50% for medically necessary orthodontics	
Deductible (waived for Class I)(per person)	\$200	
Out of Pocket Maximum (OOP) (per person)	\$350	
Out of Pocket Maximum*** (OOP) (per family - 2+ children)	\$700	
Annual Maximum	N/A	
Ortho Lifetime Maximum	N/A	
Waiting Period	None	

*\*This plan is available for individuals up to age 19.*

*\*\*Out of Network benefits are based on the maximum amount which the In-Network Dentist has agreed with Premier Access to accept as payment in full for the dental service.*

*\*\*\*2 family members must each meet the out of pocket maximum in a plan year. Once fulfilled the family maximum has been met and will not be applied to additional family members.*

Adult-ONLY* Premier Choice Plan	In-Network	Out-of- Network**
<b>Class I/Preventive</b> - Cleanings, Exams, Space Maintainers, Emergency Pain, Radiographs-Bitewings and Radiographs (Full Mouth X-ray, Panoramic Film).	100%	100%
<b>Class II/Basic</b> - Fluoride, Sealants, Restorations (Amalgams &Anterior Resin), Simple Extractions, Surgical Extractions, Oral Surgery, Endodontics, Periodontal Maintenance, Periodontics and Anesthesia.	80%	80%
<b>Class III/Major</b> - Inlay, Onlays, Crowns, Crown Repair, Bridges, Bridge Repairs, Dentures and Denture Repair.	50%	50%
<b>Class IV/Orthodontia</b>	N/A	
Deductible*** (waived for Class I)(per person)	\$50	
Out of Pocket Maximum (OOP) (per person)	N/A	
Out of Pocket Maximum (OOP) (per family - 2+ children)	N/A	
Annual Maximum	\$1,000	
Ortho Lifetime Maximum	N/A	
Waiting Period (Waived with proof of prior coverage)****	6 months for Basic Services and 12 months for Major Services	

*\*This plan is available for individuals ages 19 and over.*

*\*\*Out of Network benefits are based on the maximum amount which the In-Network Dentist has agreed with Premier Access to accept as payment in full for the dental service.*

*\*\*\*When 3 Insureds meet the Deductible, no additional Deductibles will be required to be met for that plan year.*

*\*\*\*\*Prior coverage with a group plan not more than 30 days lapse prior to effective date.*



## Texas Essential Health Benefit – Premier Choice Family Plan with EHB (for Children)

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

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**

- Oral Exams
  - Limited to twice in a 12 month period for any combination of oral exams
- X-Rays
  - Bitewings limited once every 12 months (not a benefit in addition to a complete mouth series)
- Prophylaxis (Cleaning)
  - Limited to once in a 12 month period
- Topical Fluoride Treatment
  - Limited to twice in a 12 month period
- Sealants
  - Sealant applications are limited to once per 24 month period, on un-restored pit and fissures of a 1<sup>st</sup> and 2<sup>nd</sup> permanent molar.
- Space Maintainer
  - Only for premature loss of deciduous (baby) posterior (back) teeth.
- Palliative Treatment
  - Treatment of Emergency Pain

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

- X-Rays
  - Full x-rays complete series (includes bitewings) limited to once in 60 months.
  - Panoramic films limited to twice in a 12 month period
- Amalgam (silver) Restorations
  - Multiple restorations on 1 surface will be considered a single filling.
  - Multiple restorations on different surfaces of the same tooth will be considered connected.
  - Limited to once in 24 months
- Resin (tooth colored) Restorations – Anterior (front) teeth ONLY
  - Limited to once in 24 months for the same covered amalgam (resin) restoration
- Resin (tooth colored) Restorations – Posterior (back) teeth ONLY
  - Limited to the benefit of the corresponding amalgam restoration
  - Prior to placement member must be informed and agree to pay the cost difference
- Coronal remnants – deciduous tooth
- Extraction of erupted teeth or exposed root
- 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
- General anesthesia and intravenous sedation, limited as follows:
  - Considered for payment as a separate benefit only when medically necessary (as determined by the Plan) 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 and nitrous oxide are covered for children through the age of 13



## Texas Essential Health Benefit – Premier Choice Family Plan with EHB (for Children)

### Class III: Major Dental Services

- Therapeutic pulpotomy (primary tooth) excluding final restoration
  - Benefit only for primary (baby) teeth
- Root canal therapy (anterior/bicuspid/molar) excluding final restoration
  - Benefit for permanent teeth only.
- Recement crown
- Prefabricated stainless steel crown (primary and permanent teeth); Prefabricated resin crown (anterior teeth only); Prefabricated stainless steel crown with resin window (anterior teeth only)
  - If more than one restoration is used to restore a tooth, benefit allowance will be paid for the most inclusive service;
  - Prefabricated crowns per tooth are benefits once in 24 month period
- Surgical removal of erupted teeth
- Removal of impacted teeth
  - Pathology removal of 3<sup>rd</sup> molar is not a covered benefit.

### Class IV: Orthodontia

- Orthodontia is covered when medically necessary and pre approved by the plan.

### General Exclusions

Covered Services and Supplies do not include:

- 1) Treatment which:
  - a) is not included in the list of Covered Services and Supplies;
  - b) is not Dentally Necessary; or
  - c) is 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, We 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 will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under Employers who notify Us that they employ 20 or more Employees during the previous business year, this exclusion will not apply to an Actively at Work Employee and/or his or her spouse who is age 65 or older if the Employee elects coverage under this Policy instead of coverage under Medicare.
- 3) Services or supplies resulting from or in the course of Your or Your Dependent's regular occupation for pay or profit for which You or Your Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Plan of all such benefits.
  - 4) Services or supplies provided by a Dentist, Dental Hygienist, denturist or doctor who is:
    - a) a Close Relative or a person who ordinarily resides with You or a Dependent;
    - b) an Employee of the Employer;
    - c) the Employer.
  - 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 three years, as determined by the Plan.
  - 6) All services for which a claim is submitted 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,



## Texas Essential Health Benefit – Premier Choice Family Plan with EHB (for Children)

- 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.
  - 9) Covered services and supplies obtained while outside of the United States, except for Emergency Dental Care.
  - 10) Correction of congenital conditions or replacement of congenitally missing permanent teeth not covered, regardless of the length of time the deciduous tooth is retained.
  - 11) Diagnostic casts, unless for medically necessary orthodontia.
  - 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, wear, or for cosmetic purposes.
  - 15) Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting.
  - 16) Replacement of a lost or stolen Appliance or Prosthesis.
  - 17) Replacement of stayplates.
  - 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) 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.
  - 21) Therapeutic drug injection
  - 22) Completion of claim forms
  - 23) Missed dental appointments
  - 24) Porcelain and cast crowns
  - 25) Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam resin filling.
  - 26) Pathology free third molar extraction or removal
  - 27) Crown build-up is not covered as a separate service
  - 28) Temporary tooth stabilization, other than covered space maintainers, is not covered
  - 29) Oral sedation and nitrous oxide analgesia are not covered, except for Children through age 13
  - 30) Implants, and procedures and appliances associated with them, are not benefits of Premier programs
  - 31) Replacement of missing teeth prior to coverage effective date.



## Texas Essential Health Benefit – Premier Choice Family Plan with EHB (for Children)

### CLASSES OF COVERED SERVICES AND SUPPLIES (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
- 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 1 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 1 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 1 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 1 film per arch per 6 month period.
  - Extraoral x-rays, limited to 1 film per 6 month period.
  - Other x-rays (except films related to orthodontic procedures or temporomandibular joint dysfunction).

#### Class II: Basic Dental Services

- Amalgam and composite restorations, limited as follows:
  - Multiple restorations on 1 surface will be considered a single filling.
  - Multiple restorations on different surfaces of the same tooth will be considered connected.
  - 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-



## Texas Essential Health Benefit – Premier Choice Family Plan with EHB (for Children)

- 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
- Space maintainers, including all adjustments made within 6 months of installation.
- Stainless steel crowns, limited to 1 per 36 month period for teeth not restorable by an amalgam or composite filling.
- 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 1 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 to the Plan for review.
  - Following osseous surgery root planing is a benefit after 36 months in the same area.
- 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.
- Periodontal related services as listed below, limited to 1 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.
  - 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.
- 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



## Texas Essential Health Benefit – Premier Choice Family Plan with EHB (for Children)

- 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 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 (as determined by the Plan) 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.
- 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.
  - 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 is limited to 3 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.



## Texas Essential Health Benefit – Premier Choice Family Plan with EHB (for Children)

- 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 1 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:
  - 1 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 1 time per 12 month period.
- Relining dentures is a covered benefit 12 months after initial insertion of the denture.
  - Limited to 1 time per 12 month period
- Tissue conditioning is limited to 1 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 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.

### EXCLUSIONS AND LIMITATIONS

#### Treatment Outside of the Covered Service Area

Treatment outside of the United States is not covered, unless the treatment is for emergency care. Coverage for emergency services is limited to a reimbursement amount of \$100.00. Please refer to your Certificate of Insurance for additional information regarding emergency care.

#### Missing Teeth Limitation

Initial placement of a full denture, partial denture or fixed bridge will not be covered by the Plan to replace teeth that were missing prior to the effective date of coverage for You or Your Dependents. However, expenses for the replacement of teeth that were missing prior to the effective date will only be considered for coverage, if the tooth was extracted within 12 months of the effective date of the Policy and while You or Your Dependent were covered under a Prior Plan.





## Texas Essential Health Benefit – Premier Choice Family Plan with EHB (for Children)

### 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 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:
  - 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 Plan 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 will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under Employers who notify the Plan that they employ 20 or more Employees during the previous business year, this exclusion will not apply to an Actively at Work Employee and/or his or her spouse who is age 65 or older if the Employee elects coverage under this Policy instead of coverage under Medicare.
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 entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Plan of all such benefits.
4. Services or supplies provided by a Dentist, Dental Hygienist, denturist or doctor who is:



## Texas Essential Health Benefit – Premier Choice Family Plan with EHB (for Children)

- a. a Close Relative or a person who ordinarily resides with You or a Dependent;
  - b. an Employee of the Employer;
  - c. the Employer.
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, as determined by the Plan.
  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.
  9. Services and supplies obtained while outside of your covered state and/or the United States, except for Emergency Dental Care.
  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 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. (unless for medically necessary orthodontia)
  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. Orthodontic services, supplies, appliances and Orthodontic-related services, unless an Orthodontic rider was included in the Policy.
  25. Oral sedation and nitrous oxide analgesia are not covered.
  26. Therapeutic drug injection.
  27. Completion of claim forms.
  28. Missed dental appointments.
  29. Replacement of missing teeth prior to coverage effective date

**IMPORTANT NOTICE REGARDING LANGUAGE ASSISTANCE & DISCRIMINATION**  
**AVISO IMPORTANTE SOBRE LA ASISTENCIA DE IDIOMA Y DISCRIMINACIÓN**

<p><b>English</b></p>	<p>If you or the person you are helping has questions about your insurance benefits, claims, or coverage, you have the right to get help and information in your language at no cost. To talk to an interpreter: if you have insurance from your employer, call the telephone number on your identification card; for all other members, please call 844-561-5600.</p> <p>The Guardian and its subsidiaries* comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.</p>
<p><b>Spanish</b> <b>Español</b></p>	<p>Si usted o la persona que está ayudando tiene preguntas acerca de su seguro, las reclamaciones o cobertura, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete: si tiene seguro de su empleador, llame al número de teléfono que aparece en su tarjeta de identificación; para todos los demás miembros, por favor llame al 844-561-5600.</p> <p>The Guardian y sus subsidiarias * cumplir con las leyes federales aplicables de derechos civiles y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad, o sexo.</p>
<p><b>Chinese</b> <b>中文</b></p>	<p>如果你或你正在帮助的人拥有你的保险利益、索赔或覆盖的问题，你有没有成本，以获取帮助和信息在你的语言的权利。要交的解释：如果您从您的雇主有保险，打电话给你的身份证上的电话号码；所有其他成员，请致电 844-561-5600。</p> <p>卫报及其子公司*遵守适用的联邦民权法和种族，肤色，国籍，年龄，残疾，或性的基础上不歧视。</p>
<p><b>Vietnamese</b> <b>Tiếng Việt</b></p>	<p>Nếu bạn hoặc người bạn đang giúp đỡ có câu hỏi về quyền lợi bảo hiểm, yêu cầu của bạn, hoặc bảo hiểm, bạn có quyền được trợ giúp và thông tin trong ngôn ngữ của bạn miễn phí. Để nói chuyện với một thông dịch viên: nếu bạn có bảo hiểm từ công ty của bạn, hãy gọi số điện thoại trên thẻ nhận dạng của bạn; cho tất cả các thành viên khác, xin vui lòng gọi 844-561-5600.</p> <p>The Guardian và các công ty con của nó * tuân thủ pháp luật quyền dân sự liên bang áp dụng và không phân biệt đối xử trên cơ sở chủng tộc, màu da, nguồn gốc quốc gia, tuổi tác, khuyết tật, hoặc quan hệ tình dục.</p>
<p><b>Korean</b> <b>한국어</b></p>	<p>당신이나 당신이 도움이 되고 사람이 당신의 보험 혜택, 청구, 또는 범위에 대한 질문이 있는 경우, 당신은 무료로 귀하의 언어로 도움과 정보를 얻을 수 있는 권리가 있습니다. 통역 얘기하려면, 당신은 당신의 고용주로부터 보험이 있는 경우, 귀하의 ID 카드에 전화 번호로 전화; 다른 모든 구성원에 대해, 844-561-5600로 전화 해주십시오.</p> <p>가디언과 그 자회사는 해당 연방 민권법을 준수하고 인종, 피부색, 출신 국가, 연령, 장애, 또는 성별에 근거하여 차별하지 않습니다*.</p>
<p><b>Tagalog</b> <b>Tagalog</b></p>	<p>Kung ikaw o ang taong ikaw ay pagtulong ay may mga katanungan tungkol sa inyong mga benepisyo sa insurance, claims, o coverage, ikaw ay may karapatan upang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makipag-usap sa isang interpreter: kung mayroon kang insurance mula sa iyong tagapag-empleyo, tawagan ang numero ng telepono sa iyong identification card; para sa lahat ng iba pang mga miyembro, mangyaring tumawag sa 844-561-5600.</p> <p>The Guardian at ang mga subsidiaries * sumusunod sa naaangkop na mga Pederal na batas sa mga karapatang sibil at hindi maaaring makita ang kaibhan sa batayan ng lahi, kulay, bansang pinagmulan, edad, kapansanan, o sex.</p>
<p><b>Russian</b> <b>Русский</b></p>	<p>Если вы или человек, которому вы помогаете есть вопросы по поводу вашего страховых выплат, претензий, или покрытия, вы имеете право получить помощь и информацию на вашем языке без каких-либо затрат. Для того, чтобы поговорить с переводчиком: если у вас есть страхование от Вашего работодателя, позвоните по номеру телефона на вашей идентификационной карточке; для всех остальных членов, просьба звонить по телефону 844-561-5600.</p> <p>The Guardian и его дочерние компании * соответствии с действующими федеральными законами о гражданских правах и не допускать дискриминации по признаку расы, цвета кожи, национального происхождения, возраста, инвалидности или пола.</p>
<p><b>Arabic</b> <b>العربية</b></p>	<p>إذا كنت أنت أو الشخص الذي يساعد فيه أسئلة حول فوائد التأمين والمطالبات، أو تغطية، لديك الحق في الحصول على المساعدة والمعلومات في لغتك دون أي تكلفة. التحدث الى مترجم: إذا كان لديك التأمين من صاحب العمل الخاص بك، الاتصال على رقم الهاتف على بطاقة الهوية الخاصة بك. لجميع الأعضاء، يرجى الاتصال 844-561-5600.</p> <p>الجاردريان والشركات التابعة لها * الالتزام بالفوانين الاتحادية المطبقة الحقوق المدنية ولا تميز على أساس العرق أو اللون أو الأصل القومي أو السن أو الإعاقة، أو الجنس..</p>
<p><b>French Creole-Haitian Creole</b> <b>Kreyòl Ayisyen</b></p>	<p>Si ou menm oswa moun nan w ap ede gen kesyon sou benefis asirans ou, reklamasyon, oswa pwoteksyon, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou a pa koute. Pou pale ak yon entèprèt: si ou gen asirans nan men anplwayè ou, rele nimewo telefòn sou kat idantifikasyon ou; pou tout lòt manm, tanpri rele 844-561-5600.</p> <p>The Guardian ak filiales li yo * konfòme yo avèk lwa sou dwa sivil Federal aplikab yo, epi pa fè diskriminasyon sou baz ras, koulè, orijin nasyonal, laj, andikap, oswa fè sèks.</p>
<p><b>Polish</b> <b>Polskie</b></p>	<p>Jeśli Ty lub osoba, do której pomoc ma pytania dotyczące świadczeń z ubezpieczenia, roszczenia lub pokrycia, masz prawo do uzyskania pomocy i informacji w swoim języku, bez żadnych kosztów. Aby rozmawiać z tłumacza: jeśli masz ubezpieczenie od pracodawcy, należy zadzwonić pod numer telefonu na karcie identyfikacyjnej; dla wszystkich pozostałych członków, zadzwoń 844-561-5600.</p> <p>The Guardian i jej spółek zależnych * przestrzegania obowiązujących przepisów federalnych praw obywatelskich i nie dyskryminacji ze względu na rasę, kolor skóry, pochodzenie narodowe, wiek, niepełnosprawność, czy płeć.</p>

<p><b>French</b> <b>Français</b></p>	<p>Si vous ou la personne que vous aidez a des questions sur vos prestations d'assurance, les prétentions ou la couverture, vous avez le droit d'obtenir de l'aide et de l'information dans votre langue, sans frais. Pour parler à un interprète: si vous avez l'assurance de votre employeur, appelez le numéro de téléphone sur votre carte d'identité; pour tous les autres membres, s'il vous plaît appelez 844-561-5600.</p> <p>The Guardian et ses filiales * sont conformes aux lois fédérales relatives aux droits civils applicables et ne fait pas de discrimination sur la base de la race, la couleur, l'origine nationale, l'âge, le handicap ou le sexe.</p>
<p><b>Italian</b> <b>Italiano</b></p>	<p>Se voi o la persona che state aiutando ha domande circa la vostra prestazioni assicurative, reclami, o la copertura, si ha il diritto di richiedere assistenza e informazioni nella propria lingua, senza alcun costo. Per parlare con un interprete: se avete l'assicurazione dal datore di lavoro, chiamare il numero di telefono sulla carta d'identità; per tutti gli altri membri, si prega di chiamare 844-561-5600.</p> <p>The Guardian e le sue controllate * conformi alle leggi federali vigenti diritti civili e non discrimina sulla base di razza, colore, nazionalità, età, disabilità, o di sesso.</p>
<p><b>Persian-Farsi</b> <b>فارسی-فارسی</b></p>	<p>اگر شما یا شخصی که شما در حال کمک به سوالات در مورد مزایای بیمه خود را، ادعا می کنید، و یا پوشش، شما حق دریافت کمک و اطلاعات به زبان خود را بدون هیچ هزینه داشته باشید. برای صحبت با یک مترجم: اگر بیمه از کارفرمای خود، تماس با شماره تلفن بر روی کارت شناسایی خود را. برای همه اعضای دیگر، لطفاً 844-561-5600 تماس بگیرید..</p> <p>گاردین و شرکتهای تابعه آن * * * * مطابق با قوانین فدرال حقوق مدنی قابل اجرا می کند و بر اساس نژاد، رنگ پوست، ملیت، سن، معلولیت و یا رابطه جنسی قائل نمی شود.</p>
<p><b>Armenian</b> <b>Հայերեն</b></p>	<p>Եթե դուք կամ այն անձը, դուք օգնում ունի հարցեր ձեր ապահովագրական հատուցումներից, պահանջների, կամ լուսաբանման, դուք իրավունք ունեք ստանալու օգնություն եւ տեղեկատվություն Ձեր լեզվով ոչ մի գնով: Խոսել է թարգմանչի: Եթե ունեք ապահովագրություն Ձեր գործատուի, զանգահարեք հեռախոսահամարը Ձեր նույնականացման քարտ. բոլոր մյուս անդամների համար, խնդրում ենք զանգահարել 844-561-5600.</p> <p>The Guardian եւ իր դուստր ձեռնարկություններն * համապատասխան են կիրառելի դաշնային քաղաքացիական իրավունքների օրենքների եւ չի խտրականություն հիման վրա ռասայի, մաշկի գույնի, ազգային ծագման, տարիքի, հաշմանդամության, կամ սեռից:</p>
<p><b>German</b> <b>Deutsche</b></p>	<p>Wenn Sie oder die Person, die Sie helfen, Fragen zu Ihrem Versicherungsleistungen , Ansprüche oder Abdeckung, haben Sie das Recht auf kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um auf einen Dolmetscher sprechen: Wenn Sie eine Versicherung von Ihrem Arbeitgeber haben, rufen Sie die Telefonnummer auf der Ausweiskarte ; für alle anderen Mitglieder, rufen Sie bitte 844-561-5600.</p> <p>The Guardian und ihre Tochtergesellschaften * mit den geltenden Bundes Bürgerrechte Gesetze einhalten und nicht zu diskriminieren auf der Grundlage von Rasse, Hautfarbe , nationaler Herkunft, Alter, Behinderung oder Geschlecht.</p>
<p><b>Portuguese</b> <b>Português</b></p>	<p>Se você ou a pessoa que você está ajudando tem dúvidas sobre seus benefícios de seguro, reivindicações, ou cobertura, você tem o direito de obter ajuda e informações na sua língua, sem nenhum custo. Para falar com um intérprete: se você tem seguro de seu empregador, ligue para o número de telefone no seu cartão de identificação; para todos os outros membros, ligue para 844-561-5600.</p> <p>Este aviso tem informações importantes sobre a sua aplicação ou sua cobertura de seguro. Olhe para as datas-chave neste</p> <p>The Guardian e suas subsidiárias * cumprir com as leis federais aplicáveis direitos civis e não discriminar com base em raça, cor, nacionalidade, idade, deficiência ou sexo.</p>

\*Guardian Life Insurance Company of America subsidiaries includes First Commonwealth Companies, Managed Dental Care, Inc., Managed Dental Guard, Inc., Premier Access Insurance Company and Access Dental Plan, Inc.