PEDIATRIC DENTAL RIDER

This rider accompanies Your Oscar Insurance Company of Texas Individual Policy document. Please refer to your Policy for detailed description of the rights and obligations between You and Us, and to Your Schedule of Benefits for Cost- Sharing requirements, day or visit limits, and Preauthorization requirements that apply to these benefits, or call Us at 1-855-Oscar-55 for more information.

For Members up to age 19, We cover medically necessary dental services including diagnostic services, preventive services, restorative services, adjunctive services, implants, and orthodontics.

Dental services are limited to the least costly treatment. Dental procedures not covered are available at dental office's usual and customary fee.

Payment of benefits is based on the Maximum Allowable Charge. In-Network dentists have agreed to accept a set of reduced fees, plus applicable copayments, as payments in full and cannot charge You more.

Out-of-Network dentists are not contracted with Us and can Balance Bill You for the difference between their actual charges and the Usual, Customary and Reasonable (UCR) charge We reimburse for that specific dental procedure. UCR charges are what is determined customary within the range of charges made for the same service or supply by other providers of similar training or experience in that general geographic area. We will reimburse a portion of the UCR charges for services by Out-of-Network Providers, but You will be responsible for paying the entire balance between what the Out-of-Network Provider actually charges (which could be much higher than the UCR charge) and what We reimburse. **To ensure that You do not receive any additional charges, please visit an In-Network dentist.**

Pretreatment Estimate

A pretreatment estimate is a valuable tool for You. It gives You an idea of the Out- of-Pocket costs associated with a particular service, and allows You to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic,

prosthetic, or orthodontic care. The pretreatment estimate is recommended, but not required to get benefits for Covered Services. A pretreatment estimate does not authorize treatment or determine its Medical Necessity, and does not guarantee benefits.

Optional Treatment

Optional treatment" means a service outside of what Your Plan covers. Unless specified, You will be responsible for the full payment for any "optional" treatment You choose. Payment for an "optional treatment" will not count towards Your Deductible or Out-of-Pocket Maximum.

Emergency Dental Care

We Cover emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.

Preventive Dental Care

We Cover preventive dental care that includes procedures which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing the teeth) at six (6) month intervals;
- Topical fluoride application at six (6) month intervals;
- Sealants on the first and second unrestored permanent molars (one tooth per 36 months);
- Preventive resin restoration, permanent teeth (one per tooth per 36 months); and
- Unilateral or bilateral space maintainers.

Diagnostic Dental Care

We Cover diagnostic dental care provided in the office of a dentist, including:

- Dental examinations every six (6) month consecutive period;
- Extensive problem focused examinations;
- Full mouth x-rays or panoramic x-rays at sixty (60) month intervals, bitewing x-rays at six (6) month intervals, and other single x-rays if Medically Necessary (once primary teeth erupt);

Restorative Dental Care

We Cover restorative services

- Amalgam, composite and protective restorations and stainless steel crowns;
- Other restorative materials appropriate for children;
- Replacement of a restoration if it is defective, as shown by conditions such as

recurrent decay or fracture;
- Single crowns at sixty (60) month intervals, only if there is not enough retentive quality left in the tooth to hold a filling. We will cover up to five units of crown or bridgework per arch; upon the sixth unit the treatment is considered full mouth reconstruction and is an optional treatment;
- Core buildup, including any pins at sixty (60) month intervals;
- Resin infiltration at thirty-six (36) month intervals; and
- Implants at sixty (60) month intervals.

Oral Surgery

We Cover oral surgery provided in the office of a dentist, including:

- Procedures for simple extractions and other dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Deep sedation;
- Therapeutic parenteral drug, single administration;
- Other Oral surgery;
- Bone grafts are not covered when done in connection with extractions, apicoectomies, or non-covered/non-eligible implants;
- Collection and application of autologous blood at thirty-six (36) month intervals.

Endodontics

We Cover root canals, apexification/recalcification, apicoectomy, and hemisection, including procedures for treatment of diseased pulp chambers, pulp canals, and pulpal therapy (limited to primary incisor for members up to age six (6) and for primary molars and bicuspids up to age eleven (11)), where Hospitalization is not required. Pulpotomy included with cost of root canal if root canal was complete within forty-five (45) days of pulpotomy.

Periodontics

We Cover gum disease treatment at thirty-six (36) month intervals, four (4) periodontal cleanings at twelve (12) month intervals after active periodontal therapy (regular cleanings will apply to the limitation), scaling and root planning at twenty-four (24) month intervals, and osseous surgery at thirty-six (36) month intervals, tissue grafting (non-autogenous connective tissue graft, first tooth per site/quadrant at thirty-six (36) month intervals) and one (1) full mouth debridement, including periodontic services in anticipation of, or leading to orthodontics Covered under this Policy.

Prosthodontics

We Cover prosthodontic services as follows:

- Fixed Prosthodontics, e.g. single crown, onlays and pontics at sixty (60) month intervals;
- Implants to support dentures at sixty (60) month intervals;
- Removable complete, partial or immediate dentures, including six (6) months follow-up care, at sixty (60) month intervals; and
- Additional services including insertion of identification slips, adjustments, repairs, relines and rebases and treatment of cleft palate.

Fixed bridges are not Covered unless they are required

- For replacement of a missing permanent single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full compliment of natural, functional and/or restored teeth;
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.
- We will cover up to five units of crown or bridgework per arch; upon the sixth unit the treatment is considered full mouth reconstruction and is an optional treatment.

Adjunctive Services

The following services are covered in dental office setting only:

- In-office conscious sedation;
- Deep sedation/general anesthesia, only in conjunction with covered oral and pedodontic procedures when dispensed in a dental office by a practitioner acting within the scope of his/her licensure;
- Therapeutic parenteral drug, single administration; and
- Occlusal guard at twelve (12) month intervals for patients.

Orthodontics

We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);

- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

DENTAL BENEFITS: EXCLUSIONS

1. Any procedures not covered under this Policy or Rider
2. Dental procedures or services performed solely for Cosmetic purposes or that is not Dentally Necessary and/or medically necessary (unless specifically listed as a Covered Service in this Rider)
3. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving You or Your Dependent's dental health, as determined by Us based on generally accepted dental standards of care.
4. Orthognathic surgery.
5. Inpatient/outpatient hospital charges of any kind, including prescriptions or medications, except for palliative care for an Emergency Dental Condition. General anesthesia or IV sedation is not covered for any reason if rendered in an outpatient facility or hospital. Dental charges will be covered, if the procedure performed is covered by the Plan.
6. Replacement of Dentures, Crowns, appliances or Bridgework that have been lost, stolen or damaged.
7. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a Covered Service in this Rider. Any services related to pathology laboratory fees.
8. Procedures, appliances, or restorations whose primary purpose is to change the vertical dimension of occlusion, correct congenital malformation, developmental, or medically induced dental disorders including, but not limited to, treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specifically listed as a Covered Service.
9. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
10. Dental services required while serving in the armed forces of any country or international authority.
11. Dental services considered Experimental or Investigational in nature. If We make a determination that a Dental service is Experimental or Investigational in nature, this Adverse Determination may be appealed as described in Your

Policy.

12. Treatment required due to an accident from an external force, unless otherwise listed as Covered Service
13. The following are not included as Orthodontic benefits:
    a. Repair or replacement of lost or broken appliances;
    b. Retreatment of Orthodontic cases;
    c. Treatment involving: Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia; Hormonal imbalances or other factors affecting growth or developmental abnormalities, unless specifically covered as medically necessary orthodontia;
    d. Treatment related to temporomandibular joint disorders, unless specifically covered as medically necessary orthodontia;
    e. Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances. Invisalign services are excluded.