RIDER TO QUALCHOICE EVIDENCE OF COVERAGE

(FORM # QCLHIC SG NGF PPO EOC (1-2018)) FOR

PEDIATRIC DENTAL BENEFITS

This rider (the "Pediatric Dental Rider") amends the QualChoice Life and Health Insurance Company, Inc. Evidence of Coverage (Form # QCLHIC SG NGF PPO EOC (1-2018)) (the "Certificate") and the Benefits Summary issued to the Enrollee and is therefore part of the Group Master Contract that is a legal document between QualChoice Life and Health Insurance Company, Inc. and your Employer Group. Unless otherwise stated herein, this Pediatric Dental Rider is subject to all terms, conditions, exclusions and limitations set forth in the Certificate, the Benefits Summary, and the Group Master Contract.

We have capitalized certain words in this Pediatric Dental Rider. Those words have special meanings and, unless defined otherwise in this Pediatric Dental Rider, are defined in Section 13, "Definitions", of the Certificate.

For purposes of this Pediatric Dental Rider and each section of this Pediatric Dental Rider, QualChoice Life and Health Insurance Company, Inc. (d/b/a "QualChoice") is referred to as "us", "we" or "our", and "you" or "your" means the Certificate Holder, i.e., the Employee.

The last paragraph of the existing Section 3.7 is substituted in its entirety with the following:

Unless covered under Section 3.5, Section 3.6, Section 3.7, or Section 3.8, no dental care or orthodontic services are covered.

The existing Section 3.8 is substituted in its entirety with the following:

3.8 Dental – Pediatric

For a Child under the age of nineteen (19), we will cover basic dental services including routine examinations and cleanings, fluoride application, dental x-rays, cavity repair with amalgam, pulpotomies, simple extractions, dental consultations, and care of abscesses. Periodontal therapy, root canals, full and acrylic partial dentures and repairs thereof, biopsies, surgical extractions, and crowns may be covered for a Child under the age of nineteen (19) if authorized by QualChoice. The following specific limits and requirements apply:

1. Preventive Services:
   a. One (1) screening exam every six (6) months.
   b. Complete dental x-rays every five (5) years, and bitewings every six (6) months.
   c. Prophylaxis (cleaning) and fluoride treatment once every six (6) months.
   d. Sealant on first and second permanent molars.
2. Space maintainers are only covered when a deciduous tooth is lost earlier than expected, where there is likely to be a significant shift in tooth spacing as a result, and where a permanent tooth is going to fill the space.
3. Restorations
   a. Amalgam restorations are covered for all teeth.
   b. Composite restorations are only covered for anterior teeth. Composites posterior to the cuspids will be paid at the same rate as amalgam.
   c. Fillings are not covered on teeth with crowns within one (1) year of crown placement.
4. Crowns
   a. Prefabricated stainless steel crowns are covered for deciduous teeth.
   b. Prefabricated stainless steel crowns are only covered for posterior permanent teeth for loss of cuspal function.
   c. Prefabricated stainless steel or resin crowns may be covered with pre-authorization for anterior teeth in Enrollees below the age of fourteen (14).

   d. Porcelain to metal crowns may be covered in unusual cases for anterior incisors and cuspids.
5. Extractions
   a. Simple extractions and simple surgical extractions are covered.
   b. Complex surgical extractions (with unusual surgical complications of cutting procedure to remove residual roots) require submission of records for review of Medical Necessity prior to payment.
6. Anesthesia and analgesia
   a. General anesthesia requires pre-authorization. See QualChoice Medical Policies for criteria.
   b. Intravenous conscious sedation is covered when Medically Necessary. Pre-authorization is not required, but post payment review may be performed.
   c. Nitrous oxide is covered when used with a surgical procedure or a covered pediatric dental procedure other than examination, prophylaxis, fluoride, sealants, or x-rays.

Orthodontic services are not covered. Anesthesia for dental services is covered as described in Section 3.6. Dental service for Accidental Injury is covered as described in Section 3.5. Other dental services are not covered. Please see your Benefits Summary for other limitations.

The first paragraph of the existing Section 7 is substituted in its entirety with the following:

You and your family members may have coverage under more than one health plan. This Plan contains a Coordination of Benefits (COB) provision. This is to eliminate duplication of payment for services. There is no COB for prescription drugs supplied at the retail pharmacy. COB will apply for drugs covered under the medical benefit. We do not coordinate against the following kinds of coverage: hospital indemnity coverage or other fixed indemnity coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, as defined by state law, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law. We coordinate against dental coverage in accordance with the procedures set forth in this Section 7 for coordination with other health policies.

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