SECTION XVI

Dental Care

{Drafting Note: Use Section XVI only for the Essential Plan Plus Vision and Dental, which is only available for Essential Plan 1 and Essential Plan 2 products (e.g., those whose income is above 138% through 200% FPL).}

Please refer to the Schedule of Benefits section of this [Contract; Policy] for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.
{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage.}

We Cover the following dental care services:

A. 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.

B. 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; two (2) times per Plan Year].
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C. Routine Dental Care. We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations, visits and consultations [once within a six (6) month consecutive period (when primary teeth erupt); two (2) times per Plan Year];
- X-rays, full mouth x-rays or panoramic x-rays at 36-month intervals, bitewing x-rays at six (6) to 12-month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for children.

D. Endodontics. We Cover endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

E. Periodontics. We Cover periodontic services, including periodontic services in anticipation of, or leading to orthodontics [or cosmetic orthodontics] Covered under this [Contract; Policy].

F. Prosthodontics. We Cover prosthodontic services as follows:

- Removable complete or partial dentures, including six (6) months follow-up care; and
- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

Fixed bridges are not Covered unless they are required:

- For replacement of a 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.

G. 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).