

## SECTION XVI

### Dental Care

*{Drafting Note: Effective January 1, 2025, use Section XVI for all Essential Plan Tiers.}*

Please refer to the Schedule of Benefits section of this [Contract; Policy] for 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].
- 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; and
  - In-office conscious sedation; and
  - Amalgam and composite restorations (fillings)

#### **D. Crowns**

We Cover crowns, including stainless steel crowns, when Medically Necessary. Preauthorization is required.

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

We cover root canal therapy when Medically necessary.

**F. Periodontics.** We Cover limited periodontic services. We Cover non-surgical periodontic services. We Cover periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. We also Cover periodontic services in anticipation of, or leading to orthodontics [or cosmetic orthodontics] that are otherwise Covered under this [Certificate; Contract; Policy].

We Cover crown lengthening only when associated with Medically Necessary crown or root canal procedure. Preauthorization is required.

**G. Prosthodontics.** We Cover prosthodontic services as follows:

- Removable complete or partial dentures, including six (6) months post-delivery care, when they are Medically Necessary, including when necessary to alleviate a serious condition or one that is determined to affect employability; and
- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate. Preauthorization is required.

Complete dentures and partial dentures, whether unserviceable, lost, stolen, or broken will not be replaced for a minimum of eight (8) years from initial placement except when determined to be Medically Necessary. Preauthorization requests for replacement dentures prior to eight (8) years must include a letter from Your dentist, explaining the specific circumstances that necessitates replacement of the denture. If replacement dentures are requested within the eight (8) year period after they have already been replaced once, then supporting documentation must include an explanation of preventative measures instituted to alleviate the need for further replacements.

#### **General Guidelines for All Removable Prosthesis:**

Complete and/or partial dentures will be approved only when the existing prosthesis is not serviceable and cannot be relined or rebased. Reline or rebase of an existing prosthesis will not be covered when such procedures are performed in addition to a new prosthesis for the same arch within six (6) months of the delivery of a new prosthesis. Only "tissue conditioning" is covered within six (6) months prior to the delivery of new prosthesis.

Cleaning of removable prosthesis or soft tissue not directly related to natural teeth or implants is not a covered service. Prophylaxis and/or scaling and root planning is only covered when performed on natural dentition.

"Immediate" prosthetic appliances are not a covered service.

#### **Other Removable Prosthetic Services**

"Tissue conditioning" for treatment reline using materials designed to heal unhealthy ridges prior to more definitive final restoration is the **ONLY** type of reline covered within six (6) months prior to the delivery of a new prosthesis. Insertion of tissue conditioning liners in existing dentures is limited to once per denture unit.

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 complement 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.

**Dental Implant Services.** We Cover dental implants, including single implants, and implant related services, when Medically Necessary. Preauthorization is required for implant services.

Preauthorization requests for implants must have supporting documentation from Your dentist. Your dentist's office must document, among other things, Your medical history, current medical conditions being treated, list of all medications currently being taken, explaining why implants are Medically Necessary and why other covered functional alternatives for prosthetic replacement will not correct Your dental condition, and certifying that You are an appropriate candidate for implant placement. If Your dentist indicates that You are currently being treated for a serious medical condition, documentation from Your treating physician may be required.

**H. Oral Surgery.** We Cover non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth. We also Cover oral surgery in anticipation of, or leading to orthodontics [or cosmetic orthodontics] that are otherwise Covered under this [Certificate; Contract; Policy].

**I. 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).

**J. How to Access Dental Services.** If You need to find a dentist or change Your dentist, please call [name of Dental Vendor] at [insert number and days/times] or please call Us at [insert number and days/times]. Customer Service Representatives are there to help You. Many speak Your language or have services that will translate in any language You need.]