WAC 284-43-5700 Essential health benefit category—Pediatric oral services. A health benefit plan must include "pediatric dental benefits" in its essential health benefits package. Pediatric dental benefits means coverage for the oral services listed in subsection (3) of this section, delivered to those under age nineteen.

(1) For benefit years beginning January 1, 2015, a health benefit plan must include pediatric dental benefits as an embedded set of benefits, or through a combination of a health benefit plan and a stand-alone dental plan that includes pediatric dental benefits certified as a qualified dental plan. For a health benefit plan certified by the health benefit exchange as a qualified health plan, this requirement is met if a stand-alone dental plan meeting the requirements of subsection (3) of this section is offered in the health benefit exchange for that benefit year.

(2) The requirements of WAC 284-43-5640 and 284-43-5780 are not applicable to the stand-alone dental plan. A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The supplemental base-benchmark plan specifically excludes oral implants, and an issuer should not include benefits for oral implants in establishing a plan's actuarial value.

(3) **Supplementation:** The base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-5640, but does not cover pediatric oral services. Because the base-benchmark plan does not cover pediatric oral benefits, the state EHB-benchmark plan requirements are supplemented for pediatric oral benefits. The Washington state CHIP plan is designated as the supplemental base-benchmark plan for pediatric dental benefits. A health plan issuer must offer coverage for and classify the following pediatric oral services as pediatric dental benefits in a manner substantially equal to the supplemental base-benchmark plan:

(a) Diagnostic services;

(b) Preventive care;

(c) Restorative care;

(d) Oral surgery and reconstruction to the extent not covered under the hospitalization benefit;

(e) Endodontic treatment;

(f) Periodontics;

(g) Crown and fixed bridge;

(h) Removable prosthetics; and

(i) Medically necessary orthodontia.

(4) The supplemental base-benchmark plan's visit limitations on services in this category are:

(a) Diagnostic exams once every six months, beginning before one year of age;

(b) Bitewing X-ray once a year;

(c) Panoramic X-rays once every three years;

(d) Prophylaxis every six months beginning at age six months;

(e) Fluoride three times in a twelve-month period for ages six and under; two times in a twelve-month period for ages seven and older; three times in a twelve-month period during orthodontic treatment; sealant once every three years for occlusal surfaces only; oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment;

(f) Every two years for the same restoration (fillings);

(g) Frenulectomy or frenuloplasty covered for ages six and under without prior authorization;

(h) Root canals on baby primary posterior teeth only;

(i) Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32;

(j) Periodontal scaling and root planing once per quadrant in a two-year period for ages thirteen and older, with prior authorization;

(k) Periodontal maintenance once per quadrant in a twelve-month period for ages thirteen and older, with prior authorization;

(l) Stainless steel crowns for primary anterior teeth once every three years; if age thirteen and older with prior authorization;

(m) Stainless steel crowns for permanent posterior teeth once every three years;

(n) Metal/porcelain crowns and porcelain crowns on anterior teeth only, with prior authorization;

(o) Space maintainers for missing primary molars A, B, I, J, K, L, S, and T;

(p) One resin based partial denture, if provided at least three years after the seat date;

(q) One complete denture upper and lower, and one replacement denture per lifetime after at least five years from the seat date;

(r) Rebasing and relining of complete or partial dentures once in a three-year period, if performed at least six months from the seat date.

(5) This section expires on December 31, 2016.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5700, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5700, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-879, filed 9/29/15, effective 9/29/15. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-09-080 (Matter No. R 2013-19), § 284-43-879, filed 4/18/14, effective 5/19/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-879, filed 7/9/13, effective 7/10/13.]