



# Dental SBCs

## Dental Plan Technical Advisory Committee

March 20, 2024

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# Agenda

**Today:** Reviewing Dental SBC Considerations

**Next Steps:** Feedback due on March 27



# HBE Dental SBC Background

- Dental SBCs were created at the inception of the Exchange by OSP in partnership with Dental TAC members.
  - The Dental SBCs have yet to be updated
- Dental SBCs are linked on the Dental Plan Details Page on Healthplanfinder

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PLAN OPTIONS

Companion Life  
EMV HEALTH

**WA Individual Advantage PPO**

Provider and facility [Edit](#)

**Routine care**  
Covered at no cost to you - 50%  
Coinsurance after deductible for children / Covered at no cost to you - Not Covered for adults

**Restorative care**  
50% - 100% Coinsurance after deductible for children / 50% - Not covered for adults

**Estimated premium**  
\$15.60 /month

**Deductible**  
\$75.00 Adult / \$75.00 Child

**Annual benefit limit**  
Unlimited for children / \$1,000.00

**Additional information**

RESOURCES AND DOCUMENTS

Specialist referrals required [No](#)

Preauthorization required [No](#)

Summary of benefits and coverage [Open Summary of Benefits and Coverage](#)

This is a list of commonly used benefits. It is not all inclusive. Before selecting a plan, review the plan's Summary of Benefits and Coverage (SBC) for more information on benefits and exclusions.

# Policy Considerations

- Structure: Some states separated adult and child into two separate SBCs as many adult services are not covered
  - HBE has proposed to maintain the current SBC structure with each service broken out by adult and child coverage
- Comprehensive list of services: Some states included a greater number of services listed on their SBC
  - HBE has proposed to include more services on the Dental SBC
- Waiting Period: Waiting periods are not disclosed in SBCs are on *healthplanfinder*
- Matrix: California included a matrix of Benefits, Limitations and Exclusions
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  - Further discussion needed on how this should be included for maximum customer value

# Structure Example: Adult & Child

Dental Treatment	Services You May Need	Your Cost If You Use an In-Network Provider	<sup>1</sup> Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
Medically Necessary Orthodontia	Braces	Adult: Not Covered	Not Covered	Not Covered
		Child: 50%	50%	Cosmetic orthodontic services, like teeth straightening for a more attractive smile, are not covered. Medically orthodontic services must be preauthorized before treatment is performed.
	Removable appliances	Adult: Not Covered	Not Covered	Not Covered
		Child: 50%	50%	Replacing or repair of removable orthodontic retainers, or orthodontic appliances are not covered. Medically orthodontic services must be preauthorized before treatment is performed.

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# Proposed Services to Include

Routine Check-up	<u>Oral</u> Exams	Adult:		
		Child:		
	<u>Teeth</u> Cleanings	Adult:		
		Child:		
	Fluoride	Adult:		
		Child:		
	Sealants	Adult:		
		Child:		
	<u>Full Mouth X-rays</u>	<u>Adult:</u>		
		<u>Child:</u>		
	<u>Bitewing</u> X-rays	Adult:		
		Child:		
	<u>Single Tooth X-rays</u>	<u>Adult:</u>		
		<u>Child:</u>		
	<u>Space Maintainers</u>	<u>Adult:</u>		
		<u>Child:</u>		
	Nitrous oxide	Adult:		
		Child:		

# Proposed Services to Include

Filling a Cavity	<u>Amalgam (Silver Filings) Front Tooth</u>	Adult:		
		Child:		
	<u>Amalgam (Silver Filings) Back Tooth</u>	<u>Adult:</u>		
		<u>Child:</u>		
	Composite <u>Front Tooth</u>	Adult:		
		Child:		
	<u>Composite Back Tooth</u>	<u>Adult:</u>		
		<u>Child:</u>		
	Nitrous oxide	Adult:		
		Child:		
	<u>Temporary Filings</u>	<u>Adult:</u>		
		<u>Child:</u>		

# Proposed Services to Include

Restorative Care	<u>Periodontal Maintenance/ Cleaning</u> (Treatment of gums)	Adult:		
		Child:		
	<u>Periodontal Scaling and Root Planing</u>	Adult:		
		Child:		
	Crowns	Adult:		
		Child:		
	<u>Replacement of a Crown</u>	Adult:		
		Child:		
	<u>Onlays</u>	Adult:		
		Child:		
	Root canals ( <u>per tooth</u> )	Adult:		
		Child:		
	<u>Vital Pulpotomy</u>	Adult:		
		Child:		
	<u>Replacement of teeth</u>	Adult:		
		Child:		

# Proposed Services to Include

Tooth Extraction	Extraction <i>(per tooth)</i>	Adult:		
		Child:		
	<u>Surgical Extraction</u>	<u>Adult:</u>		
		<u>Child:</u>		

Advanced Oral Surgery	Oral surgery	Adult:		
		Child:		
	<u>Periodontal Surgery</u>	<u>Adult:</u>		
		<u>Child:</u>		
	<u>General Anesthesia</u>	<u>Adult:</u>		
		<u>Child:</u>		
	<u>Minor treatment for Pain Relief</u>	<u>Adult:</u>		
		<u>Child:</u>		

# Proposed Services to Include

Medically Necessary Orthodontia	Braces	Adult:		
		Child:		
	Removable appliances	Adult:		
		Child:		
<u>Prosthetics</u>	<u>Implants</u>	<u>Adult:</u>		
		<u>Child:</u>		
	<u>Partial Dentures</u>	<u>Adult:</u>		
		<u>Child:</u>		
	<u>Complete Dentures</u>	<u>Adult:</u>		
		<u>Child:</u>		
	<u>Bridge or Denture Repair</u>	<u>Adult:</u>		
		<u>Child:</u>		
	<u>Rebase or Reline of Dentures</u>	<u>Adult:</u>		
		<u>Child:</u>		

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# Waiting Period

## Current Opportunity

- HBE has received complaints that the Dental SBCs do not provide clear communication regarding waiting periods.

## Current State Solution

- OSP will work with carriers to add a statement disclosing the waiting period in Healthplanfinder and update SBCs as needed

## Future State Options

- Include question about waiting periods on the first page of the SBC
- Waiting period disclosed at the benefit level in SBC/ limitations matrix
- Make Dental Marketing brochures accessible through link in *healthplanfinder*

**This is only a summary.** If you want more detail about dental coverage and costs under this plan, you can get the complete terms in the policy or plan document at [www.\[insert\].com](http://www.[insert].com) or by calling 1-800-[insert]

Important Questions	Answers	Why this Matters
What is the premium amount?	Adult: \$ Child: \$	The premium amount is a monthly fee you must pay to your insurance company to receive dental insurance.
What is the overall deductible?	Adult: \$ Child: \$	You must pay all the costs related to covered services up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible period starts (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Does the deductible apply to preventive services?		The deductible <b>does</b> apply to preventive exams, cleanings, or other preventive services. See the chart starting on page 2 for how much you pay for covered preventive services.
Is there an overall out-of-pocket limit on my share of dental costs?	Adult: No Child: Yes \$ for 1 child \$ for 2+ children	The out-of-pocket limit is the most you could pay during the coverage year for your share of the cost of covered services. This limit helps you plan for dental care expenses.
What is not included in the out-of-pocket limit?		Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	Adult: Yes, Child: No	There is no overall annual limit on what the plan will pay for children. The chart starting on page 2 describes any limits on what the plan will pay for adult coverage and other <i>specific</i> covered services for children.
Who is included in this plan's network of providers?	See <a href="http://www.[insert].com">www.[insert].com</a> or call 1-800-[insert] for a list of participating providers.	If you use an in-network provider, this plan will pay some or all of the cost of the covered services. Be aware, <u>your</u> in-network dentist may use an out-of-pocket provider (e.g., a hospital) for some services. Plans use the term in-network, preferred, or participating for providers in their networks. See chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?		You can see the specialist you choose <b>without</b> permission from this plan.
Do I need preauthorization before receiving certain dental services?		You <b>do</b> need to call the plan at 1-800-[insert] before receiving certain dental services. See your policy or plan document for additional information.
Are there services this plan doesn't cover?		Some of the services this plan doesn't cover are listed on page 3. See your policy or plan document for additional information about excluded services.
<u>Is there a waiting period before I can use my benefits?</u>		<u>Some insurance companies require customers to have coverage for a set number of months before their services can be used.</u>

Questions: Call 1-800-[insert] or visit us at [www.\[insert\].com](http://www.[insert].com).

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# Benefits, Limitation and Exclusions



Family Dental Plans | 2025 Adult Dental Benefits, Limitations and Exclusions

Covered Services by Frequency	Companion EMI	Delta Dental	Dentegra	Kaiser Permanente NW	LifeWise	PacificSource Dental
<b>Routine Check Up</b>						
Oral Exam						
Teeth Cleaning						
Fluoride						
Sealants						
Full Mouth X-Rays						
Bitewing X-Rays						
Single Tooth X-Rays						
Space Maintainers						
Nitrous Oxide						
<b>Filling a Cavity</b>						
Amalgam Front Tooth						
Amalgam Back Tooth						
Composite Front Tooth						
Composite Back Tooth						
Nitrous Oxide						
Temporary Filings						
<b>Restorative Care</b>						
Periodontal Maintenance/Cleaning						

## Updated Format for Benefits, Limitations & Exclusions

- Easy comparison of limitations & exclusions of plans for customers across carriers



# Family Dental Plans | 2024 ADULT DENTAL BENEFITS, LIMITATIONS AND EXCLUSIONS

Product also available to Covered California for Small Business (CCSB)

Covered Service by frequency	Anthem DHMO	Anthem DPPO	Blue Shield DHMO	Blue Shield DPPO	California Dental Network DHMO	Delta Dental DHMO	Delta Dental DPPO	Dental Health Services DHMO
Oral Exam	2 in 12 months	2 in calendar year	1 in 6 months	1 in 6 months	No frequency limitation	No frequency limitation	2 in calendar year	1 in 6 months
Prophylaxis (cleaning)	2 in 12 months	2 in calendar year	1 in 6 months	1 in 6 months	1 in 6 months	2 in 1 year	2 in calendar year	2 in 12 months
Full Mouth X-Rays	1 in 3 years	1 in 5 years	1 in 36 months	1 in 36 months	1 in 24 Months	1 in 2 years	1 in 5 years	1 in 36 months
Bitewing X-Rays	2 in 12 months	1 in 2 years	1 in 6 months	1 in 6 months	1 in 12 Months	1 in 6 months	1 in calendar year	1 in 6 months
Periodontal Maintenance (gum maintenance)	2 in 12 months (in lieu of prophylaxis)	2 in calendar year (in lieu of prophylaxis)	1 in 6 months	1 in 6 months	1 in 6 months	2 in 1 year following active treatment (in lieu of prophylaxis)	2 in calendar year following active treatment (in lieu of prophylaxis)	1 in a calendar quarter
Periodontal Scaling and Root Planing	1 per quadrant every 24 months	1 in 3 years	1 for 4 quadrants every 24 months	1 for 4 quadrants every 24 months	1 per quadrant in 12 months	4 quadrants during any 12 consecutive months	1 per quadrant every 24 months	1 per quadrant every 24 months
Filling per tooth surface	No frequency limitation	1 per tooth surface in 2 years	1 per tooth every 12 months	1 per tooth every 12 months	No frequency limitation	No frequency limitation	No frequency limitation	1 in 36 months
Replacement of a Crown	1 in 5 years	1 in 7 years	1 in 5 years	1 in 5 years	No frequency limitation	1 in 5 years	1 in 5 years	1 in 5 years
Root Canal per tooth	1 per tooth per lifetime	1 per tooth per lifetime	1 tooth per lifetime	1 tooth per lifetime	No frequency limitation	1 per tooth per lifetime	1 per tooth per lifetime	once per tooth
Extraction per tooth	No frequency limitation	1 per lifetime	1 tooth per lifetime	1 tooth per lifetime	No frequency limitation	No frequency limitation	1 per lifetime	once per tooth
Fixed Bridge Procedures	1 in 5 years	1 in 7 years	1 in 5 years	1 in 5 years	No frequency limitation	1 in 5 years	1 in 5 years	1 in 5 years
Partial Dentures	1 in 5 years	1 in 7 years	1 in 5 years	1 in 5 years	Replacement 1 in 5 years	1 in 5 years	1 in 5 years	1 in 5 years
Complete Dentures	1 in 5 years	1 in 7 years	1 in 5 years	1 in 5 years	1 in 5 years	1 in 5 years	1 in 5 years	Replacement 1 in 5 years
Excluded Services	<b>Veneers, implants, tooth whitening and adult orthodontics are excluded in all plans.</b>							
	TMJ, maxillofacial prosthetics	crown lengthening, bonding, TMJ, maxillofacial prosthetics	TMJ, cosmetic dental care maxillofacial prosthetics	TMJ, cosmetic dental care maxillofacial prosthetics	crown lengthening, TMJ	maxillofacial prosthetics	maxillofacial prosthetics, TMJ	TMJ, maxillofacial prosthetics, cosmetic dental care

This is a summary of limitations and exclusions. Please see the plan's Schedule of Benefits and Evidence of Coverage documents for complete information on covered services, limitations and excluded services.

# Questions for Feedback

## Questions

- Is the structure of this SBC industry standard?
  - Considerations: Child/adult structure, Exclusions column
  - Is this structure similar to how benefits are described in non-exchange plans?
- Are there specific services that should be included in the SBC that are not? Are there services that should be removed from the SBC?
- What is the best way to incorporate waiting period information for customers?
- Is there anything different for us to consider for child only plans and benefit description?
- Do you find the matrix useful?



## Discussion and Next Steps

- *HBE requests carriers detail the services that require a waiting period*
- *Comments on Draft 2025 SBCs due March 27*
- *Dental SBCs will be finalized April 3*