Form No: _____

Kentucky Department of Insurance

Health Product Review

KENTUCKY BENCHMARK PEDIATRIC DENTAL EHB Checklist

(Checklist must be submitted with filing – attach as a PDF if filing electronically via SERFF)

Statute/Rule	Description	Yes	No	N/A	Page #
General Requirements					
	Use this checklist in conjunction with the appropriate product checklist (i.e. Individual/ Small Group/Large Group) **This Checklist must be used will all products that contain the imbedded pediatric dental as well as the stand-alone pediatric dental products.**				
	EXCHANGE INTENTION: - Will this product be sold on the Exchange?				
	EXCHANGE CERTIFIED: Requesting this product to be considered Exchange Certified to be sold off exchange?				
	Out of Pocket Limits for Stand-alone Dental Products - $350 for one child and $700 for two or more children				
Mandated Benefits					
2017 Kentucky Benchmark	**ALL REQUIREMENTS LISTED BELOW ARE FOUND IN 2017 Kentucky Benchmark Plan**				
Diagnostic Services – Subject to Annual Deductible					
	Intraoral Bitewing Radiographs (Bitewing x-ray) = limited to 4 films per 12 months				
	Intra/Extra oral X-rays = limited to 2 films per 12 months				
	Panorex Radiographs (Full jaw x-ray) or Complete Series (full set of x-rays) = limited to 1 time per 12 months				
	Periodic Oral Evaluation (checkup exam) = Limited to 2 times per 12 months.				
Preventive Services – Subject to Annual Deductible					
	Dental Prophylaxis (Cleanings) = limited to 2 times per 12 months				
	Fluoride Treatments = limited to 2 times per				

PEDIATRIC DENTAL EHB CHECKLIST (continued)

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	12 months done in conjunction with dental prophylaxis				
	Sealants (protective coating) = limited to one per first or second permanent molar every 36 months				
Space Maintainers – Subject to Annual Deductible					
	Limited to 2 per 12 months, benefits includes all adjustments within 6 months of installation				
Minor Restorative Services, Endodontics, Periodontics, & Oral Surgery – Subject to Annual Deductible					
	Amalgam Restorations				
	Composite Resin Restorations = limited to anterior (front) teeth only				
	Endodontics (root canal therapy) = limited to 1 per tooth per lifetime				
	Periodontal Surgery (gum surgery) = limited to 1 time per quadrant per 12 months				
	Scaling & Root Planning (Deep Cleanings) = limited to 1 time per quadrant per 12 months				
	Periodontal Maintenance (gum maintenance) = limited to 2 time per 12 month period following active and adjunctive periodontal therapy with the prior 24 months – exclusive of gross debridement				
	Simple Extractions (simple tooth removal) = limited to 1 time per tooth per lifetime				
	Oral Surgery, including surgical extraction				
Adjunctive Services – Subject to Annual Deductible					
	General Services (including Emergency Treatment) = Covered as a separate benefit only if no other service was performed except for x-rays. **General anesthesia is covered when clinically necessary.** **Occlusal guard limited to 1 guard every 12 months**				
Major Restorative Services – Subject to Annual Deductible					
	Inlays/Onlays/Crowns (Partial to Full Crowns) = limited to 1 time per tooth per 60 months				
	Fixed Prosthetics (Bridges) = limited to 1 time per tooth per 60 months				
	Removable Prosthetics (Full or partial dentures) = Limited to 1 per 60 months				

PEDIATRIC DENTAL EHB CHECKLIST (continued)

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Statute/Rule	Description	Yes	No	N/A	Page #
	Relining and Rebasing Dentures = limited to relining/rebasing performed more than 6 months after initial insertion **Limited to one time per 12 months**				
	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns = limited to repairs or adjustments performed more than 12 months after the initial insertion. **Limited to 1 per 6 months**				
Implants – Subject to Annual Deductible					
	Implant Placement = Limited to 1 time per tooth per 60 months				
	Implant Supported Prosthetics = Limited to 1 time per tooth per 60 months				
	Implant Maintenance Procedures = Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. **Limited to 1 time per tooth per 60 months**				
	Repair Implant Supported Prosthesis By Report = limited to 1 time per tooth per 60 months				
	Abutment Supported Crown (Titanium) or Retainer Crown for FPD – Titanium = limited to 1 time per tooth per 60 months				
	Repair Implant Abutment by Support = limited to 1 time per tooth per 60 months				
	Radiographic/Surgical Implant Index by Report = limited to 1 time per tooth per 60 months				
Medically Necessary Orthodontics – Subject to Annual Deductible					
Benefits for comprehensive orthodontic treatment are approved only the following areas: cleft lip and/or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy, severe craniofacial deformities resulting in physically handicapping malocclusion					
	Medically necessary orthodontic services				