

Dental Benefit Details

2023

This document provides additional details about the supplemental dental benefits that are covered under our plan. The *Dental Benefit Details* applies to the 2023 plan benefit packages shown below. The plan benefit package is on the cover of the *Evidence of Coverage*, on the lower right corner. For more information about this document or your dental benefits, please contact Member Services at the phone number or web address shown on the back cover of the *Evidence of Coverage* or on your Member ID card.

State	Plan Benefit Package	Plan Name
AL	H4343001000	Ascension Complete St. Vincent's Reward (HMO)
AL	H4343002000	Ascension Complete Providence Reward (HMO)
FL	H8225001000	Ascension Complete Florida Reward (HMO)
FL	H8225009000	Ascension Complete Florida Reward II (HMO)
IL	H7399001000	Ascension Complete Illinois Reward (HMO)
IN	H7925001000	Ascension Complete St. Vincent Reward (HMO)
KS	H5398004000	Ascension Complete Via Christi Reward II (HMO)
MI	H0482001000	Ascension Complete Michigan Reward (HMO)
MI	H0482003000	Ascension Complete Michigan Reward (HMO)
TN	H2853001000	Ascension Complete Saint Thomas Reward (HMO)
TX	H6678001000	Ascension Complete Seton Reward (HMO)
TX	H6678003000	Ascension Complete Providence Reward (HMO)

Please contact your plan for details.

Ascension Complete

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Covered Dental Benefits: Our plan provides coverage for the dental services described below. Refer to your 2023 *Evidence of Coverage* for any applicable cost sharing and benefit maximum.

Dental 2023 Schedule of Benefits

Category	Code	General Service Description	Frequency (how often our plan will pay)
Diagnostic (Preventive) Services			
Oral Exam	D0120	Routine periodic exam completed during check-up	2 (D0120) per 12 months; not within 6 months of D0150
Oral Exam	D0140	Limited exam to evaluate a problem	2 (D0140, D0160) per 12 months
Oral Exam	D0150	Comprehensive exam (for a new patient, or an established patient after 3 or more years of inactivity from dental treatment)	1 (D0150) every 36 months; not within 36 months of D0120
Oral Exam	D0160	Detailed and extensive problem focused exam	2 (D0140, D0160) per 12 months
Oral Exam	D0170	Re-evaluations	2 (D0170) every 12 months
Oral Exam	D0171	Re-evaluations	2 (D0171) every 12 months
Oral Exam	D0180	Comprehensive periodontal evaluation	2 (D0180) every 12 months; not on same date as D0120 or D0150
Dental X-Rays	D0210	Full mouth/complete x-ray set for evaluation of the teeth and mouth	1 of (D0210, D0330, D0701, D0709) every 36 months
Dental X-Rays	D0220	X-rays for closer evaluation around the roots of teeth	1 (D0220) per date of service
Dental X-Rays	D0230	X-rays for closer evaluation around the roots of teeth	4 (D0230) per date of service
Dental X-Rays	D0240	Intraoral, occlusal radiographic image	1 every 12 months
Dental X-Rays	D0250	Extra-oral radiographic image	1 every 36 months
Dental X-Rays	D0251	Extra-oral radiographic image	2 every 12 months

Category	Code	General Service Description	Frequency (how often our plan will pay)
Dental X-Rays	D0270-D0274	Bitewing x-rays for evaluation of the teeth and bone	2 of (D0270-D0274) every 12 months
Dental X-Rays	D0277	Bitewing x-rays for evaluation of the teeth and bone	1 (D0277) every 36 months
Dental X-Rays	D0310	Sialography	1 (D0310) every 36 months
Dental X-Rays	D0330	Whole-mouth x-ray for evaluation of the teeth and mouth	1 of (D0210, D0330, D0701, D0709) every 36 months
Dental X-Rays	D0340, D0350	2-Dimensional photo or x-ray image	1 (D0340, D0350) every 36 months
Dental X-Rays	D0391	Reading of an x-ray or photo image by a practitioner not associated with taking the x-ray or photo, including report	1 (D0391) per date of service; allowed only when submitted along with D0701-D0709
Dental X-Rays	D0701-D0702	Whole-mouth and 2-Dimensional x-ray images of the head	1 each (D0701, D0702) every 36 months; only 1 (D0210, D0330, D0701, D0709) every 36 months
Dental Photos	D0703	Photo images, image capture only	1 (D0703) every 36 months
Dental X-Rays	D0705	X-rays taken outside the mouth	2 every 12 months
Dental X-Rays	D0706	X-rays taken inside the mouth	2 every 12 months
Dental X-Rays	D0707	X-rays for closer evaluation around the roots of teeth – image capture only	1 (D0707) per date of service
Dental X-Rays	D0708	Bitewing x-rays for evaluation of the teeth and bone – image capture only	2 of (D0708) every 12 months
Dental X-Rays	D0709	Full-mouth/Complete x-ray set for evaluation of the teeth and mouth – image capture only	1 of (D0210, D0330, D0701, D0709) every 36 months

Category	Code	General Service Description	Frequency (how often our plan will pay)
Diagnostic	D0414-D0416	Tests and examinations	1 (D0414-D0416) every 12 months per test
Diagnostic	D0460	Tooth nerve test	1 (D0460) per tooth per date of service
Diagnostic	D0431, D0472-D0502	Oral pathology laboratory	1 (D0431, D0472-D0502) every 12 months per test
Preventive Services			
Other Services	D1110	Standard adult dental cleaning	2 (D1110) every 12 months
Fluoride	D1206, D1208	Fluoride treatment	1 (D1206, D1208) every 12 months
Other Services	D0604, D0605	COVID antigen/antibody testing	1 (D0604, D0605) per date of service
Comprehensive Other Adjunctive (Non-Routine) Services			
Other Comprehensive Services	D9110	Minor procedure for emergency treatment of dental pain	1 (D9110) per 12 months
Other Comprehensive Services	D9410-D9420, D9997	Visits to or from nursing homes, hospitals, surgery centers or doctors' offices	1 (D9410, D9420, D9997) per date of service
Other Comprehensive Services	D9995	Teledentistry - performed in real time	Only 1 of any (D9995-D9996) per date of service
Other Comprehensive Services	D9996	Teledentistry - performed when information stored and sent to a dentist for later review	

Exclusions:

- Services or supplies for correction of congenital or developmental malformations.
- Cosmetic dentistry services or surgery for aesthetic purposes (including the treatment of congenital or developmental malformations, bleaching of teeth and grafts to improve aesthetics).
- Charges for hospitalization, laboratory tests, and histopathological examinations.

- Charges for failure to keep a scheduled appointment with the Dentist.
- Services or supplies for which no valid dental need can be demonstrated.
- Services or supplies that do not meet accepted standards of dental practice.
- Services or supplies that are investigational or experimental in nature, including services required to treat complications from investigational or experimental procedures.
- Services or supplies covered under a hospital, surgical/medical (including Medicare Advantage), or prescription drug program.
- Appliances, restorations, or services for the diagnosis or treatment of disturbances or dysfunction of the temporomandibular joint (TMJ).
- Appliances, surgical procedures, and restorations (amalgam or composite resin fillings, crowns, bridges, inlays, or onlays) for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting.
- Services or supplies not listed in the above table.

Treatment Completion Date

Treatment completion date is defined as the date that treatment is complete and may be billable. Treatment is complete on dates of delivery for removable complete and partial dentures, final cementation for crowns and bridges, and final fill for root canals.

Prior Authorization

Prior Authorization is required prior to treatment for certain codes and address issues of eligibility and available benefits at time of request. This is not a guarantee of payment. Approval for payment is based upon the member's eligibility on the date of service, dental record documentation, and any policy limitations and remaining available benefits on the date of service.