

WAC 284-43-5704 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 19. Plans must provide this coverage for enrollees until at least the end of the month in which the enrollee turns age 19.

(1) For benefit years beginning January 1, 2026, 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 (4) of this section is offered in the health benefit exchange for that benefit year.

(2) The requirements of WAC 284-43-5644 and 284-43-5784 are not applicable to the stand-alone dental plan.

(3) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes oral implants, and an issuer should not include benefits for oral implants in establishing a plan's actuarial value.

(4) The base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-5644 and covers pediatric oral services. The designated base-benchmark plan for pediatric dental benefits consists of the benefits and services covered within Appendix B - Washington Essential Health Benefits Benchmark Plan and Appendix C - State EHB Benchmark Summary of Benefits as approved by the department of health and human services Centers for Medicare and Medicaid Services on October 7, 2024, as available on the commissioner's website.

(a) Pediatric preventive and diagnostic dental services.

(i) Bitewing x-rays;

(ii) Cephalometric films;

(iii) Complete intra-oral mouth x-rays;

(iv) Diagnostic casts when dentally appropriate;

(v) Limited oral evaluations to evaluate the member for a specific dental problem or oral health complaint, dental emergency, or referral for other treatment;

(vi) Limited visual oral assessments or screenings not performed in conjunction with other clinical oral evaluation services;

(vii) Occlusal intraoral x-rays;

(viii) Oral hygiene instruction if not billed on the same day as a cleaning;

(ix) Periapical x-rays that are not included in a completed series for diagnosis in conjunction with definitive treatment;

(x) Photographic images (oral and facial) when dentally appropriate;

(xi) Periodic and comprehensive oral examinations, limited to two per member per calendar year, beginning before one year of age;

(xii) Problem focused oral examinations;

(xiii) Panoramic mouth x-rays;

(xiv) Cleanings, limited to two per member per calendar year;

(xv) Sealants;

(xvi) Space maintainers (fixed unilateral or fixed bilateral), subject to the following limits:

- (A) Recementation of space maintainers;
- (B) Removal of space maintainers; and
- (C) Replacement space maintainers are covered when dentally appropriate.
- (xvii) Topical fluoride application when dentally appropriate.
- (b) Basic dental services.
 - (i) Complex oral surgery procedures including:
 - (A) Surgical extractions of teeth;
 - (B) Impactions;
 - (C) Alveoloplasty;
 - (D) Vestibuloplasty;
 - (E) Residual root removal;
 - (F) Frenulectomy;
 - (G) Frenuloplasty.
 - (ii) Emergency treatment for pain relief.
 - (iii) Endodontic services consisting of:
 - (A) Apexification for apical closures of anterior permanent teeth;
 - (B) Apicoectomy;
 - (C) Debridement;
 - (D) Direct pulp capping;
 - (E) Pulpal therapy;
 - (F) Pulp vitality tests;
 - (G) Pulpotomy; and
 - (H) Root canal treatment.
 - (iv) Endodontic benefits will not be provided for indirect pulp capping.
 - (v) Fillings consisting of composite and amalgam restorations, limited to the following:
 - (A) A maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars;
 - (B) A maximum of six surfaces per tooth for teeth one, two, three, 14, 15, and 16;
 - (C) A maximum of six surfaces per tooth for permanent anterior teeth;
 - (D) Restorations on the same tooth are limited to once in a two-year period; and
 - (E) Two occlusal restorations for the upper molars on teeth one, two, three, 14, 15, and 16.
 - (vi) General dental anesthesia or intravenous sedation administered in connection with the extractions of partially or completely bony impacted teeth. Other services related to general anesthesia or intravenous sedations are covered as follows:
 - (A) Drugs and/or medications only when used with parenteral conscious sedation, deep sedation, or general anesthesia;
 - (B) Inhalation of nitrous oxide, once per day; and
 - (C) Local anesthesia and regional blocks, including office-based oral or parenteral conscious sedation, deep sedation, or general anesthesia.
 - (vii) Periodontal services consisting of:
 - (A) Complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery);
 - (B) Debridement limited to once per member in a three-year period;
 - (C) Gingivectomy and gingivoplasty limited to once per member per quadrant in a three-year period;

(D) Periodontal maintenance limited to once per quadrant in a calendar year; and

(E) Scaling and root planning limited to once per member per quadrant in a two-year period.

(viii) Uncomplicated oral surgery procedures including removal of teeth, incision, and drainage.

(c) Major dental services.

(i) Adjustments and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within one year of insertion;

(ii) Behavior management;

(iii) Bridges (fixed partial dentures), except that benefits will not be provided for replacement made fewer than seven years after placement;

(iv) Crowns and crown build-ups, limited to the following:

(A) An indirect crown in a five-year period, per tooth, for permanent anterior teeth for members with fully erupted permanent anterior teeth;

(B) Cast post and core or prefabricated post and core, on permanent teeth when performed in conjunction with a crown;

(C) Core build-ups, including pins, only on permanent teeth when performed in conjunction with a crown;

(D) Recommendations of permanent indirect crowns for members with fully erupted permanent anterior teeth;

(E) Stainless steel crowns for primary posterior teeth once in a three-year period; and

(F) Stainless steel crowns for permanent posterior teeth (excluding teeth one, 16, 17, and 32) once in a three-year period.

(v) Dental implant crown and abutment related procedures, limited to one per member per tooth in a seven-year period;

(vi) Dentures, full and partial, including:

(A) Denture rebase, limited to one per member per arch in a three-year period, if performed at least six months from the seating date;

(B) Denture relines, limited to one per member per arch in a three-year period, if performed at least six months from the seating date;

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

(D) One resin-based partial denture, replaced once within a three-year period.

(vii) Home visits, including extended care facility calls, limited to two calls per facility per provider;

(viii) Medically necessary orthodontic services for members with malocclusions associated with:

(A) Cleft lip and palate, cleft palate, and cleft lip with alveolar process involvement; and

(B) Craniofacial anomalies for hemifacial microsomia, craniosynostosis syndromes, anthrogryposis, or Marfan syndrome.

(ix) Occlusal guards;

(x) Post-surgical complications;

(xi) Repair of crowns is limited to one per tooth;

(xii) Repair of implant supported prosthesis or abutment, limited to one per tooth.

(5) An issuer must supply pediatric dental exclusions in a manner substantially equal to the base-benchmark plan.

(6) Pediatric dental plans must categorize covered dental services in a manner consistent with the essential health benefit benchmark plan (i.e., preventative and diagnostic services, basic services, major services, etc.).

(7) Issuers must know and apply relevant guidance, clarifications, and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently asked questions jointly issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor, and the U.S. Department of the Treasury.

(8) This section applies to health plans that have an effective date of January 1, 2026, or later.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5704, filed 12/19/25, effective 1/19/26.]