DENTAL CLINICAL GUIDELINES

These dental clinical guidelines have been developed as a general overview of clinical criteria for benefit plans offered by subsidiaries of Unum Group including Unum, Colonial Life & Accident, Colonial Voluntary Benefits, and Starmount Life Insurance. This guide is intended as a reference for Providers and also includes administrative information regarding pre-treatment estimates and claim filing. This is only a guide and is not intended to be all-inclusive. The information provided is subject to the member's benefit plan including covered benefits, exclusions, and limitations. In the event of a conflict, the member's benefit plan will prevail.

This version of the guidelines supersedes all other prior versions published and are subject to change at any time. Applicable federal and state regulations supersede these guidelines.

TABLE OF CONTENTS

GENERAL

Pre-treatment estimate (PTE)

A pre-treatment estimate provides, in advance, approximately what portion of the expenses will be covered by the benefit plan. Pre-treatment estimates are non-binding and not a guarantee of payment as final determination of benefits payable is made when treatment is complete and may be impacted by the members eligibility for benefits, annual or lifetime maximums, coordination of benefits and other factors.

Pre-treatment estimates are not required for any service. However, if the charges for treatment is expected to exceed $300, we recommend a pre-treatment estimate. The estimate may be for a less expensive alternate benefit payable under the benefit plan.

To submit a pre-treatment estimate request:
By Mail: Claims Department, PO Box 80139, Baton Rouge, LA 70898-0139
By Email: DentalClaims@unum.com
By Fax: 1-855-400-9307

Limitations & Exclusions

We will not provide benefits for any of the following and we will not pay benefits for a claim that is caused by, contributed to/by, or occurs as a result of any of the following. See the members plan for a full list of Limitations and Exclusions.

- Services or supplies not included in the Schedule of Covered Procedures
- Treatments which are elective or primarily cosmetic in nature and not generally recognized as an accepted dental practice by the American Dental Association, this also includes any replacement of prior elective or cosmetic procedures
- Experimental or investigational drugs, devices, treatments, or procedures
- Replacement of a removeable device or appliance that is lost, missing or stolen, and for the replacement of removeable appliances that have been damaged due to abuse, misuse, or neglect. This may include but not be limited to removable partial dentures or dentures
- Replacement of any permanent or removeable device or appliance unless the device or appliance is no longer functional and is older than the limitation in the Schedule of Covered Procedures. This may include but not be limited to bridges, dentures, and crowns
- Any appliance, service, or procedure performed for the purpose of splinting, to alter vertical dimension or to restore occlusion
- Any appliance, service, or procedure performed for the purpose of correcting attrition, abrasion, erosion, abfraction, bite registration, or bite analysis
- Procedures provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, and myofascial pain
- Orthognathic surgery

- Prescribed medications, pre-medication, or analgesia
- General anesthesia, intravenous sedation, and the services of anesthetists or anesthesiologists, except in conjunction with complex oral surgery in which anesthesia is medically necessary
- Instruction for diet, plaque control, and oral hygiene
- Charges for implants unless specified in the Covered Procedures, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments
- Restorations for teeth, unless necessary due to deterioration from extensive decay or accidental Injury
- Treatment of malignancies, cysts, and neoplasms
- Charges for failure to keep a scheduled visit or for the completion of claim forms
- Procedures which do not offer a favorable prognosis, are not medically necessary, or do not meet generally acceptable standards of care
- Requests for a duplicate removeable device or appliance
- The replacement of 3rd molars
- Restorations used to restore teeth with micro fractures or fracture lines, undermined cusps, or large existing restorations without over pathology

Alternate Benefit

There are multiple options for dental treatment, all of which provide acceptable results. An Alternate Benefit may be applied if there is a less expensive covered procedure appropriate for the course of treatment, capable of producing acceptable results. When an alternate benefit is applied, the less expensive alternate benefit is used to determine the amount payable under the certificate.

If an alternate benefit is applied, the member is responsible for any remaining allowable amount after benefits are paid by the plan.

Missing Teeth Limitation

Please refer to the members certificate of coverage or policy to verify if a missing tooth limitation applies.

Start and end of treatment

For benefits to be payable, covered procedures must be started and completed while a member's coverage is in force.

Dental Treatment	START DATE, is the date:	COMPLETION DATE, is the date:
Full or partial denture	First impression is taken	Final completed prosthesis is first inserted in the mouth
Fixed bridge, crown, inlay and onlay	Teeth are first prepared	Bridge or restoration is permanently cemented in place
Root canal therapy	Pulp chamber is first opened	Canal is permanently filled
Periodontal surgery	Surgery is performed	Surgery is performed
All other treatment	Treatment is rendered	Treatment is rendered

[1]A prosthetic dental appliance completed after a member's coverage ends, may be payable for up to 30 days from the date coverage ended.

ORAL EVALUATIONS

Most plans provide two oral evaluations per benefit year to assess any changes in oral health since the last visit. The most common oral evaluation is the periodic oral evaluation performed each time a member visits their dentist. Benefits for a comprehensive oral exam may be payable when:

- It is the member's first visit as a new patient to the dentist
- The member has had a significant change in health and proper documentation is provided
- The member has not seen their dentist for over 3 years

Otherwise, an alternate benefit for a periodic oral evaluation may be applied.

DIAGNOSTICS

On any single date of service, 8 or more periapical radiographs or a panoramic film in conjunction with bitewings, will be paid an alternate benefit of a complete series of radiographic images.

RESTORATIVE

A tooth that requires multiple restorations on one surface will be payable as only one surface. Multiple surfaces on a single tooth will not be paid as separate restorations.

Fillings

- Limited to 1 restoration by tooth surface per tooth
- Depending on the members plan, when an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, we may base our benefit on the amalgam filling which is the less expensive alternative benefit

Inlays, onlays, & crowns

- Limited to permanent teeth including inlay, onlay, or any type of crown per tooth
- Depending on plan, an alternative benefit may be applied

- Radiographs required – bitewings, periapicals or panorex
- Evidence of tooth damage by caries or trauma must be present
- Must have a minimum of 50% bone support
- No active periodontal disease
- May be covered when a direct or more conservative restoration is not feasible
- Onlays must completely cover at least one cusp of the posterior tooth and involve multiple surfaces

Note: Restorations for the purpose of splinting, to alter vertical dimension or to restore occlusion; or restorations performed for the purpose of correcting attrition, abrasion, erosion, abfraction, bite registration, or bite analysis are not covered.

Crowns

An endodontically treated tooth must show adequate root canal fill without excessive over-fill and be asymptomatic.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated. Temporary or permanent crowns are not separate benefits, and any payment made for a temporary crown will be deducted from payment for the permanent crown.

Core Buildups

A core buildup is allowed for a posterior tooth when one cusp is missing down to, or closer than, 2mm from the gum tissue in preparation for a restorative crown. A core buildup is allowed for an anterior tooth when more than ½ of the mesial-distal width of the incisal edge is missing down past the junction of the incisal and middle third of the tooth. Buildups are covered on endodontically treated teeth without an existing crown only if the below criteria are met.

- The tooth must be sufficiently broken down that a buildup is required for adequate support and retention of a crown
- Buildups are not considered for inlays or onlays as dentally necessary due to the retention of multiple tooth surfaces
- Minor restorations of carious areas, liners, bases or blocking out undercuts in a preparation do not qualify as a buildup
- Closing of endodontic access cavity does not qualify as a build-up

Post and Core

- The tooth must have had a root canal
- The tooth with a root canal must show adequate root canal fill without excessive over- or under-fill
- The tooth must be sufficiently broken down where a more conservative base or buildup would be contraindicated

- The risk of root fracture or splitting the root by placing a post is minimal

Veneers

- Limited to permanent anterior teeth
- Will not be covered if performed for cosmetic reasons

ENDODONTICS

- Radiographs required – bitewings, periapicals or panorex
- Limited to permanent teeth, maximum of 1 procedure per tooth, per lifetime
- Must be due to pathologic destruction to the tooth pulp by caries or trauma
- Root is not fractured
- Tooth must present with at least 50 percent bone support
- Tooth must be restorable
- Patient must be free of periodontal disease

PERIODONTICS

Scaling and Root Planing

- Maximum of 1 procedure per quadrant, (benefit frequency may vary by plan, please refer to the members plan to verify coverage)
- Requires pocket depths of 4mm or greater and radiographs that show bone loss
- Periodontal charting and radiographs are required
- Procedures will not be covered if performed on the same day as comprehensive exams, prophylaxis, periodontal maintenance, scaling in presence of generalized moderate or severe gingival inflammation, or debridement
- A full mouth periodontal chart is required for review. If eligible, all 4 quadrants can be done on the same day (while this procedure is usually accomplished best in two visits, some circumstance make it necessary in one visit. If done in one visit the claim should be accompanied by a narrative explaining the rationale for doing all treatment in one sitting

Surgical Periodontal services

- Benefits are based on 1 per quadrant for the following: gingivectomy or gingivoplasty, osseous surgery, connective or soft tissue graft (benefit frequency may vary by plan, please refer to the members plan to verify coverage)
- Documentation of periodontal disease confirmed by radiographs that show bone loss and periodontal charting is required
- Qualifying teeth must have at least one 5mm (or greater) pocket depth reading. For some groups, teeth adjacent to a mesial or distal 5mm (or greater) pocket depth reading are also considered to be qualifying teeth

EXTRACTIONS

Benefits for extractions include removal of the entire tooth, any necessary minor smoothing of the socket/alveolar bone, and any necessary suturing.

Surgical Extractions

- Radiographs required – bitewings and/or periapicals or Panoramic radiograph
- Removal of impacted tooth is based upon the anatomic position of the tooth, not the technique necessary for removal. Note: third molars do not automatically qualify for surgical extractions
- Benefits for any surgical extraction may be based on the alternate benefit for an erupted tooth when performed in conjunction with another surgical procedure in the same site on the same date of service by the same Dentist

Anesthesia:

- Covered for complex oral surgery, periodontal surgery or impactions, only under specific conditions (pre-treatment estimate is recommended)
- Allowed if with three (3) or more impactions or if there are two (2) lower impactions
- Clinical records, including anesthesia information, will be required for consideration

FIXED OR REMOVABLE PROSTHESIS

Replacement of any fixed or removable prosthesis includes replacement of teeth and acrylic on removable partial denture (RPD) frameworks, overdentures, dentures, implants, mini-implants, implant /abutment supported partial dentures and bridges.

Full-mouth radiograph, periodontal charting and extraction dates are required. If removable prosthesis, a panoramic radiograph may be used in lieu of a full-mouth radiograph.

There must be at least one (1) missing tooth in the arch (upper arch - tooth #'s 2 – 15, lower arch - tooth #'s 18 – 31).

Tooth # 1, 16, 17 and 32 are not eligible for replacement unless for functional occlusion and necessary to maintain occlusal support.

- All teeth must have at least 50 percent bone support and must be permanent teeth at appropriate tooth positions for good retention and stability
- Replacement of an existing appliance or dental prosthesis is excluded unless it is more than 5 years old (limitation may vary by plan) and no longer serviceable
- Replacement of an existing appliance or dental prosthesis is only allowed for same service replacement
- Adjustments and repairs are covered only after 6 months have passed after initial placement

Fixed Bridge retainer

- All abutment teeth must exhibit a minimum of 50% bone support and must be free from active periodontal disease
- If previous endodontic treatment, root canal fill must be adequate (not poorly condensed, not excessively overfilled, not excessively underfilled)

Implants

- Patient must have good general and oral health, adequate bone in their jaw to support the implant, and healthy gum tissues that are free of periodontal disease
- Implant must have good crown to "root" ratio, and not be closer than 1.5 mm to adjacent roots or implants
- Plans vary, please refer to the members plan to verify implant coverage. Plans may cover endosteal implants in lieu of a 2 or 3-unit bridge. If 2 or more teeth are billed for implants in the same arch, an alternate benefit of a partial bridge may be applied

ADMINISTRATION

Claims Submission guidelines

Most providers will submit claims on behalf of the patient. Claims should be submitted after services have been completed and may be submitted electronically or submitted with a current ADA claim form, completed in its entirety.

CLAIMS CAN BE MAILED, FAXED, OR SECURELY SUBMITTED ELECTRONICALLY TO US AT:
Electronic Payor ID: STR01
Online: AlwaysAssist.com
Email: dentalclaims@unum.com
Mail: Attn: Dental Claims
P.O. Box 80139
Baton Rouge, LA 70898
Fax: 855-400-9307

Filing a claim

- Claims should be submitted within 90 days from the date of service but no later than one (1) year or within the applicable proof of loss time frame outline in the members plan, whichever is sooner
- It is important to include the following information:
  - Name of patient (covered dependent or member)
  - Patient date of birth
  - Patient address, city, state and zip

- Patient's member ID or social security number
- Employer name if applicable
- Plan name
- Assignment of benefits, if applicable
  - Patient or insured member should sign and date both billing and treating sections of the ADA claim form to assure payment is sent to the provider. We will also accept "Signature on File"
- Procedure codes
  - Submit current Dental ADA codes for the applicable year. If using the ADA claim form, it is sections 24-30
- Date of service
  - Section 24 of the ADA claim form should be left blank if filing a pre-treatment estimate
- Treating and billing providers federal tax ID number and National Practitioner Identifier (NPI) number
- Treating and billing providers name, address, city, state, zip and phone number
- Treating and billing provider's signature

Electronic Claims Submission

We prefer claims are securely submitted electronically. Claims that are submitted electronically are usually processed more quickly. We also offer an interactive website to view benefit summaries, claims status, and a history of claims paid for our members who are your patients. To gain access to the website, you can register at www.AlwaysAssist.com or call our Customer Service team at 855-400-9330.

Utilization Review

Our affiliated insuring entities use the services of P&R Dental Strategies, Inc. (P&R) to conduct utilization review of dental claims and assist with claim reviews as needed. P&R has licensed professionals so in the event a claim requires the review of a specialist, the assigned individual is board certified and capable of assisting with the review. Utilization review provides our affiliated insuring entities the opportunity to review a request for dental treatment. Such review will help confirm whether the plan provides coverage and if the treatment is appropriate for a member's dental services.

Grievance & Appeals

If you or a member has a grievance or would like to appeal a claim, it may be submitted verbally or in writing. It is imperative that you submit all requested information (such as x-rays and patient records) as soon as possible, as failure to submit complete information may impact the ability to complete a full and fair review of the grievance or appeal. All grievances and appeals are handled in accordance with state and federal law. To initiate a grievance or appeal, please:

- Call 855-400-9330 or
- Submit in writing with the reason for the grievance/appeal and sufficient information to identify the member to: Grievance Coordinator, P.O. Drawer 98100, Baton Rouge, LA 70898-9100

REVISION HISTORY

DATE	REVISION DETAILS
1/1/2022	Document Created
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The Dental Clinical Guidelines are a general overview of the clinical criteria and subject to the members benefit plan and applicable federal and state regulations. Providers may verify benefit plan information at AlwaysAssist.com/Dental or by calling dental provider service at 855-400-9330.