Summary of Benefits Form:

Program Type:	State:
MEDICAID	**Alabama**

As a convenience for state users, summary of benefits information entered on this form is pre-populated based on the most recent submission. Also, please note that in order to ensure the information on the public website remains current and relevant, the information on these forms will be cleared if no update has been submitted in more than two years

*I. Preventive Services

Children's Dental Service	Is the Service Covered **(Yes)**	Is the Service Covered **(Only with Prior Authorization**	Is the Service Covered **(No)**	Frequency (Specify periodicity) Please select from the following:	List Any Service-specific Limitations (eg. age limits, tooth-specific limits, or a cost or dollar threshold above which prior authorization is required)	Criteria for Coverage
*A. Cleanings				1 x 2 months 1 x 3 months 1 x 5 months 1 x 6 months 1 x year 2 x year 3 x year Up to 4 x year 1 x every 2 years 1 x every 3 years		

Children's Dental Service	Is the Service Covered **(Yes)**	Is the Service Covered **(Only with Prior Authorization**	Is the Service Covered **(No)**	Frequency (Specify periodicity) Please select from the following:	List Any Service-specific Limitations (eg. age limits, tooth-specific limits, or a cost or dollar threshold above which prior authorization is required)	Criteria for Coverage
				1 x every 4 years 1 x every 5 years 1 x lifetime		
*B. Fluoride treatments (including fluoride varnishes)				1 x 2 months 1 x 3 months 1 x 5 months 1 x 6 months 1 x year 2 x year 3 x year Up to 4 x year 1 x every 2 years 1 x every 3 years 1 x every 4 years 1 x every 5 years 1 x lifetime		
*C. Sealants (list any tooth-specific limits)				1 x 2 months 1 x 3 months 1 x 5 months		

Children's Dental Service	Is the Service Covered **(Yes)**	Is the Service Covered **(Only with Prior Authorization**	Is the Service Covered **(No)**	Frequency (Specify periodicity) Please select from the following:	List Any Service-specific Limitations (eg. age limits, tooth-specific limits, or a cost or dollar threshold above which prior authorization is required)	Criteria for Coverage
				1 x 6 months 1 x year 2 x year 3 x year Up to 4 x year 1 x every 2 years 1 x every 3 years 1 x every 4 years 1 x every 5 years 1 x lifetime		
*D. Space maintainers				1 x 2 months 1 x 3 months 1 x 5 months 1 x 6 months 1 x year 2 x year 3 x year Up to 4 x year 1 x every 2 years 1 x every 3 years		

Children's Dental Service	Is the Service Covered **(Yes)**	Is the Service Covered **(Only with Prior Authorization**	Is the Service Covered **(No)**	Frequency (Specify periodicity) Please select from the following:	List Any Service-specific Limitations (eg. age limits, tooth-specific limits, or a cost or dollar threshold above which prior authorization is required)	Criteria for Coverage
				1 x every 4 years 1 x every 5 years 1 x lifetime		

*II. Diagnostic Services

Children's Dental Service	Is the Service Covered **(Yes)**	Is the Service Covered **(Only with Prior Authorization**	Is the Service Covered **(No)**	Frequency (Specify periodicity) Please select from the following:	List Any Service-specific Limitations (eg. age limits, tooth-specific limits, or a cost or dollar threshold above which prior authorization is required)	Criteria for Coverage
*A. Oral health screening or assessment				1 x 2 months 1 x 3 months 1 x 5 months 1 x 6 months 1 x year 2 x year		

Children's Dental Service	Is the Service Covered **(Yes)**	Is the Service Covered **(Only with Prior Authorization**	Is the Service Covered **(No)**	Frequency (Specify periodicity) Please select from the following:	List Any Service-specific Limitations (eg. age limits, tooth-specific limits, or a cost or dollar threshold above which prior authorization is required)	Criteria for Coverage
				3 x year Up to 4 x year 1 x every 2 years 1 x every 3 years 1 x every 4 years 1 x every 5 years 1 x lifetime		
*B. Dental examinations				1 x 2 months 1 x 3 months 1 x 5 months 1 x 6 months 1 x year 2 x year 3 x year Up to 4 x year 1 x every 2 years 1 x every 3 years 1 x every 4 years 1 x every 5 years		**List Recommended age of visit?**

Children's Dental Service	Is the Service Covered **(Yes)**	Is the Service Covered **(Only with Prior Authorization**	Is the Service Covered **(No)**	Frequency (Specify periodicity) Please select from the following:	List Any Service-specific Limitations (eg. age limits, tooth-specific limits, or a cost or dollar threshold above which prior authorization is required)	Criteria for Coverage
				1 x lifetime		
*C. Assessment of risk for tooth decay				1 x 2 months 1 x 3 months 1 x 5 months 1 x 6 months 1 x year 2 x year 3 x year Up to 4 x year 1 x every 2 years 1 x every 3 years 1 x every 4 years 1 x every 5 years 1 x lifetime		
*D. X-Rays						
*i. Bitewing				1 x 2 months 1 x 3 months 1 x 5 months 1 x 6 months 1 x year		

Children's Dental Service	Is the Service Covered **(Yes)**	Is the Service Covered **(Only with Prior Authorization**	Is the Service Covered **(No)**	Frequency (Specify periodicity) Please select from the following:	List Any Service-specific Limitations (eg. age limits, tooth-specific limits, or a cost or dollar threshold above which prior authorization is required)	Criteria for Coverage
				2 x year 3 x year Up to 4 x year 1 x every 2 years 1 x every 3 years 1 x every 4 years 1 x every 5 years 1 x lifetime		
*ii. Full Mouth				1 x 2 months 1 x 3 months 1 x 5 months 1 x 6 months 1 x year 2 x year 3 x year Up to 4 x year 1 x every 2 years 1 x every 3 years 1 x every 4 years		

Children's Dental Service	Is the Service Covered **(Yes)**	Is the Service Covered **(Only with Prior Authorization**	Is the Service Covered **(No)**	Frequency (Specify periodicity) Please select from the following:	List Any Service-specific Limitations (eg. age limits, tooth-specific limits, or a cost or dollar threshold above which prior authorization is required)	Criteria for Coverage
				1 x every 5 years 1 x lifetime		
*iii. Panoramic				1 x 2 months 1 x 3 months 1 x 5 months 1 x 6 months 1 x year 2 x year 3 x year Up to 4 x year 1 x every 2 years 1 x every 3 years 1 x every 4 years 1 x every 5 years 1 x lifetime		

*III. Treatment Services

Children's Dental Service	Is the Service Covered **(Yes)**	Is the Service Covered **(Only with Prior Authorization**	Is the Service Covered **(No)**	Frequency (Specify periodicity) Please select from the following:	List Any Service-specific Limitations (eg. age limits, tooth-specific limits, or a cost or dollar threshold above which prior authorization is required)	Criteria for Coverage
*A. Anti-microbial treatments that stop decay from spreading						
*B. Fillings						
*i. Silver amalgam						
*ii. Tooth colored composite						
*C. Crowns/tooth caps						
*i. Stainless steel crowns						
*ii. Metal (only) crowns						
*iii. Metal/porcelain crowns						
*iv. Porcelain (only) crowns						
*D. Root Canals (endodontics)						
*i. Root canals on baby teeth (pulpotomies)						
*ii. Root canals on permanent teeth						

Children's Dental Service	Is the Service Covered **(Yes)**	Is the Service Covered **(Only with Prior Authorization**	Is the Service Covered **(No)**	Frequency (Specify periodicity) Please select from the following:	List Any Service-specific Limitations (eg. age limits, tooth-specific limits, or a cost or dollar threshold above which prior authorization is required)	Criteria for Coverage
*E. Gum (periodontal) therapy						
*F. Dentures						
*i. Partial dentures						
*ii. Complete dentures						
*iii. Bridges						
G. Orthodontics						
*i. Retainers (orthodontic)						
*ii. Braces						
*H. Oral surgery						
*H. Oral surgery						
*i. Simple extractions						
*ii. Surgical extractions						
*iii. Care of abscesses						
*iv. Cleft palate treatment						
*v. Cancer treatment						
*vi. Treatment of fractures						
*vii. Biopsies						
*I. Treatment of jaw joint						

Children's Dental Service	Is the Service Covered **(Yes)**	Is the Service Covered **(Only with Prior Authorization**	Is the Service Covered **(No)**	Frequency (Specify periodicity) Please select from the following:	List Any Service-specific Limitations (eg. age limits, tooth-specific limits, or a cost or dollar threshold above which prior authorization is required)	Criteria for Coverage
problems (TMJ)						
*J. Emergency room services provided by a dentist						
*K. Inpatient Hospital Services						
*L. Anesthesia						
*i. General anesthesia						
*ii. Intravenous conscious sedation						
*iii. Non-intravenous conscious sedation						
*iv. Analgesia (nitrous oxide)						

* When this information is posted on the Insure Kids Now website, we will include a special note for orthodontic services explaining that parents and caretakers should work with their child's orthodontist to ensure that the treatment and payment terms and conditions are clear at the outset of treatment (for example, what happens in the case of a child who becomes ineligible for Medicaid or CHIP while he or she is undergoing orthodontic treatment?).

If applicable, please provide the amount of the annual cost or funding level above which prior authorization is required. If the State requires that certain services only be provided with prior authorization, please list the categories of services to which this would apply.

Please verify that the information on your State's cost sharing requirements are correct as posted on the Insure Kids Now! website www.insurekidsnow.gov. If the information is not correct, please correct it at this time.