514C.20 Mandated coverage for dental care — anesthesia and certain hospital charges.

1. Notwithstanding section 514C.6, and subject to the terms and conditions of the policy or contract, a policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage for the administration of general anesthesia and hospital or ambulatory surgical center charges related to the provision of dental care services provided to any of the following covered individuals:

a. A child under five years of age upon a determination by a licensed dentist and the child's treating physician licensed pursuant to chapter 148 or treating physician assistant licensed pursuant to chapter 148C, that such child requires necessary dental treatment in a hospital or ambulatory surgical center due to a dental condition or a developmental disability for which patient management in the dental office has proved to be ineffective.

b. Any individual upon a determination by a licensed dentist and the individual's treating physician licensed pursuant to chapter 148 or treating physician assistant licensed pursuant to chapter 148C, that such individual has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

2. Prior authorization of hospitalization or ambulatory surgical center for dental care procedures may be required in the same manner that prior authorization is required for hospitalization for other coverages under the contract or policy.

3. This section applies to the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2000:

a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

b. An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

c. An individual or group health maintenance organization contract regulated under chapter 514B.

d. Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is subject to the jurisdiction of the commissioner.

e. A plan established pursuant to chapter 509A for public employees.

4. This section shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

2000 Acts, ch 1193, §1; 2008 Acts, ch 1088, §134; 2017 Acts, ch 148, §73; 2022 Acts, ch 1066, §49