Dental - Blue Shield HMO Plans (DHMO)

Benefit Coverage

Blue Shield of California Dental HMO (DHMO) covers diagnostic and preventive services, restorative services, oral surgery, periodontics, endodontics, prosthetics, and orthodontics.

DHMO plans are administered by Blue Shield's Dental Plan Administrator (DPA). Blue Shield contracts with the Dental Plan Administrator to provide services to members. The Dental Plan Administrator manages all covered services, provided by the Dental Provider or other plan providers, to members in an appropriate manner consistent with the contract. Each member is required to select a Primary Care Dentist within their dental center. The Primary Dental Provider will:

- Help the member to decide on actions to maintain and improve dental health by providing written treatment plans that address the member's dental requirements and needs to include alternative treatment options that better address the member's dental desires and treatment outcomes.
- Provide, coordinate, and direct all necessary covered dental care services.
- Arrange referrals to plan specialists when required, including required prior authorization.
- Authorize emergency services when necessary.

Note: All services must be medically or dentally necessary. The fact that a dentist or other plan provider may prescribe, order, recommend, or approve a service, procedure or dental material does not, in-of-itself, constitute or determine dental necessity even though it is not specifically listed as an exclusion or limitation. Blue Shield may limit or exclude benefits for services which are not dentally or medically necessary to restore the function of the teeth and oral cavity.

Note: Modern dental treatment spans a board continuum from purely dental treatment (fillings, dentures, etc.) to major surgical procedures. In the event there is a question whether or not a specific procedure or treatment falls into the "dental" category or "medical" category, the Blue Shield Dental Director will be the final arbiter (the person who makes the final decision) on what category (dental or medical) the treatment best fits based on the information provided to the Blue Shield Dental Director from the attending dentist.

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Benefit Coverage *(cont'd.)*

Note: The *Evidence of Coverage*, *DHMO Benefit Guidelines*, and the *Summary of Benefits* are a summary of the Plan benefits and limitations and are not intended nor designed to cover ALL of the various specific plan benefits, dental codes, exclusions, limitations, medical-dental treatment rationale and restrictions (the totality of all utilization guidelines is maintained in the Blue Shield of California Utilization Management Matrix). In the event there is a question if a particular dental treatment or service is a benefit, Blue Shield highly recommends the member instruct their dental provider to request a "pre-authorization" for any anticipated dental treatments from the DPA before beginning any course of expensive dental treatment.

Note: If there is a question as to whether a facility, dentist, or dental specialist is a member of the Member's Provider Network, it is highly recommended the Member call Blue Shield to verify the status of the provider or facility.

The Dental Provider for each member must be located sufficiently close to the member's home or work address to ensure reasonable access to care, as determined by the DPA. A Primary Dental Provider must also be selected for a newborn or child placed for adoption.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

When the member and dentist elect(s) a more complicated or personalized procedure that is more expensive than the covered benefit, the member will be responsible for the copayment of the covered benefit plus the difference between the dentist's usual and customary fee for the covered service and the selected procedure. If no dental service appearing on the schedule of benefits is related to the procedure selected, the service is excluded.

Benefit Exclusions

General Exclusions:

Unless otherwise specifically mentioned elsewhere in the contract, DHMO Dental Plans do not provide benefits with respect to:

- Dental services not appearing on the schedule of benefits. If there is a question if a dental service is a benefit, the Member should request the provider request “pre-authorization” for the service from Blue Shield.
- Any service, procedure, or supply which is received or expenses incurred prior to the patient’s effective date of coverage. For the purpose of this limitation, the date on which a procedure shall be considered to have had expenses incurred is defined as follows:
    - For full dentures or partial dentures: on the date the final impression is taken;
    - For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared;
    - For root canal therapy: on the later of the date the pulp chamber opened or the date canals are explored to the apex;
    - For periodontal surgery: on the date the surgery is actually performed;
    - For all other services: on the date the service is performed.
- Dental treatment previously started under a Dental Plan other than Blue Shield prior to the Member’s eligibility to receive benefits under this Plan (e.g., an unfinished crown or partially completed root canal, incomplete dental implant services, and etc.).
- Dental services for cosmetic purposes (e.g., bleaching, veneer facings, crowns; porcelain on molar crowns, minor orthodontic movement of teeth, or bridges and/or dentures).
- Dental services performed in a hospital and/or any related hospital fee(s).
- Treatment to correct congenital and developmental malformations including but not limited to cleft palate/lip, anodontia, mandibular prognathism, retrognathia, overjet/overbite issues, enamel hypoplasia, enamel dysplasia, enamel discolorations, and malocclusions caused by skeletal jaw discrepancies.

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Benefit Exclusions *(cont'd.)*

- Treatments which, in the professional judgement of the DPA, have a poor prognosis when an alternative treatment with a more favorable prognosis is available. *Note*: For the purpose of this policy, the term "poor prognosis" shall be defined (based on the information provided by the attending dentist) as the inability to control local or systemic factors making periodontal breakdown likely to occur even with comprehensive periodontal treatment and maintenance. In the event there is a disagreement on the prognosis of the teeth/tooth, it shall be the responsibility of the attending dentist to provide the following information to the DPA for evaluation: Age of the patient, probing depths, furcation involvement, mobility, tooth type, and smoking habits (https://www.ncbi.nlm.nih.gov/pmc/).
- Treatment to correct or restore teeth, oral soft tissues, the alveolus, or jaws as the result of naturally occurring attrition or erosion of the oral or dental structures to include atrophy of the jaws from edentulism and/or clenching or grinding of the teeth.
- Reimbursement to the member or another dental office for the cost of services secured from dentists, other than the Dental Provider or other DHMO plan authorized provider ("in-network provider"), except:
    - When such reimbursement is expressly authorized or approved by the DHMO plan; or
    - As cited under the Emergency Services and Emergency Claims provision (thorough documentation must be provided to the DPA). It is insufficient to simply write or send an x-ray for dental treatment provided on an emergency status without appropriate medical-dental documentation on the nature of the emergency.
- Treatment for any condition for which benefits could be recovered under any worker's compensation, accident insurance, occupational disease law or when no claim is made for such benefits.
- Treatment for which payment is made by any governmental agency (e.g., the Veterans Administration, military, Indian Health Service, Denti-Cal, county public health dental clinic, or etc.), including any foreign government.
- Treatment from dentists outside the United States of America except when emergency services are necessary to initially and immediately medically stabilize the oral or dental structures due to accidental injury or trauma to the mouth and associated structures. Pre-accident or pre-trauma radiographs must be submitted for review when making a dental claim of this nature (there are no exceptions to this policy).

Benefit Exclusions *(cont'd.)*

- Temporomandibular Joint (TMJ) disorder or dysfunction to include any referred pain to the jaw joints, trismus, discomfort to the muscles of mastication to include any joint discomfort from using an oral appliance to manage obstructive sleep apnea or from/ during active or passive orthodontic treatment.
- Any oral-myofascial pain, headaches, cervicalgia, head position-postural issues, or migraines as the result of or associated with clenching, grinding of teeth (bruxism), orthodontic treatment, sudden traumatic insult to the jaws or joints, or from the use of an oral appliance to manage obstructive sleep apnea.
- Dental implants, transplants, implant abutments, ridge augmentations, bone grafts to the dental implant site or to the implant, periodontal procedures to the implant, or the implant site or teeth adjacent to the implant site, surgical implant guides, temporary crowns on implants as part of the immediate loading technique for an implant, diagnostic casts or working casts, 3-dimensional radiographs, rendering of the 3-dimensional radiographs, or removal of implants.
- The restoration of a dental implant body that was not approved or authorized by Blue Shield.
- Dental implants that the DPA believes will be used to support a denture or a fixed dental bridge.

  Note: Some Dental Plans provide a dental implant benefit and may be excluded from the policy above.
- General anesthesia including intravenous, conscious (oral route) and inhalation sedation (any medications used to alter mood, the perception of reality, calms patient anxiety will be referred to as "sedation") is considered medically necessary when its use is (a) in accordance with generally accepted professional standards, (b) due to the existence of a specific medical or developmental condition and (c) not furnished primarily for the convenience of the patient, the parents, the attending dentist or other provider, and not provided because of dental phobias, combativeness, and non-cooperation of the patient (e.g., general anesthesia requests are not a benefit because the child requires "lots of dental treatment" and it is more convenient to place the child to sleep and do all the treatments in one appointment). General anesthesia is not a benefit simply because the parents cannot "afford to take time off from work" to bring their child in for their dental appointments. General anesthesia is not a benefit because the provider will not or is unwilling to make multiple treatment appointments for the child.

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Benefit Exclusions *(cont'd.)*

Note: The site/office/physical location where general anesthesia is administered must meet the minimal requirements/regulations set-forth for the administration of a general anesthetic in an outpatient facility and have the proper license and/or permit allowing for such procedures at the office or facility from the California Dental Board (this is a State of California Regulation). The use of a mobile dental anesthesia service does not meet this requirement.

Note: Written documentation of the medical condition necessitating use of general anesthesia or intravenous or inhalation sedation must be provided by a physician (M.D. or D.O.) to the DPA or DHMO Plan. Written documentation on the medical condition of a patient from a dentist or dentist- anesthesiologist requesting medically necessary sedation services are not acceptable.

Note: Patient apprehension or patient anxiety will not constitute medical necessity when requesting intravenous sedation, general anesthesia, or inhalation analgesia (nitrous oxide gas).

Note: Mental retardation is an acceptable medical condition to justify use of general anesthesia. Autism is not necessarily a medical condition requiring the use of a general anesthetic for routine dental procedures. Documentation of a patient's degree of autism must come from the patient's medical doctor addressing the level of patient cooperation and not from a dentist or parents.

Note: The DHMO plan reserves the right to review the use of general anesthesia to determine dental or medical necessity.

Note: General anesthesia, intravenous sedation, etc. is limited to a total of 30 minutes per treatment session ("frequency limitation") regardless of the degree of difficulty of the dental procedure or the total length of time needed to complete the dental procedures.

- Dental prophylaxis more than twice per calendar year.
- Precious metals (gold and gold alloy) will be charged to the patient at the dentist's cost.
- The use of titanium metal or titanium alloy for cast metal restorations will be charged to the patient at the dentist's cost for the material.
- Replacement of an existing, lost, or stolen prosthetic appliance more than once in the five-year period commencing on the date the appliance was last supplied (delivered to the patient), whether under this contract or any prior dental care policy, unless for dental necessity.

Benefit Exclusions *(cont'd.)*

- Removal of 3rd molar (wisdom teeth) other than for dental necessity (pain, swelling, infection, causing decay to adjacent tooth). Removal of asymptomatic impacted, partially, or fully erupted 3rd impacted molars because of possibility of dental crowding or for pre or post orthodontic treatment may be considered not medically necessary by the DPA.
- Referral of a dependent child age 6 and over to a pedodontist (specialist in children's dentistry), unless for medical or dental necessity, or the child is uncooperative and will not allow the general dentist to treat after two attempts (thorough documentation must be provided to the DPA to include treatment attempts, behavioral management techniques employed, and level of uncooperativeness; there are no exceptions to this policy). All such exceptions must be approved by the DPA.
- Treatment as a result of accidental injury shall only be covered secondary to medical insurance, or any other primary insurance with accident coverage (thorough documentation must be provided to the DPA to include pre- and post-accident photographs and radiographs).
- Services, procedures, or supplies which are not reasonably necessary, medically and dentally, for the care and maintenance of the member's dental condition according to the broadly accepted standards of professional care in the United States or Canada, or which are experimental or investigational in nature or which do not have consistent-uniform professional endorsement.
- Dental treatment that does not meet Plan "utilization" guidelines (Blue Shield of California Utilization Management Matrix), frequency limitations, and/or when the mandatory "waiting period" for specified dental services have not been met.
- Any manner of prosthesis used to prevent a temporomandibular joint problem from developing (e.g., such as "morning aligners" used in conjunction with oral appliance to manage obstructive sleep apnea or during any phase of orthodontic treatment).
- Any manner of oral or facial prosthesis constructed to mask facial or jaw deformities/defects as the result of surgery, congenital, or developmental issues.
- Any dental treatment not provided by a California Dental Board licensed dentist, or a dentist not licensed to practice in the United States of America or Canada (except for emergency dental treatment to medically stabilize teeth and associated oral structures when the member is outside the United States; thorough documentation must be provided for payment).

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Benefit Exclusions *(cont'd.)*

- Any self- administered, self-prescribed dental treatment, dental therapies, or oral treatments (drug store purchased "nightguards, teething medications, self-administered teeth bleaching kits, self-administered orthodontic appliances, snore guards, appliances for obstructive sleep apnea, dental restoration kits, medications prescribed by a medical doctor for a dental problem, etc.) unless written prior approval has been obtained from the DPA.

Orthodontic Exclusions:

- Treatment already "in-progress" (after banding) at inception of eligibility. "After banding" is defined as the initial treatment taken by an orthodontist to prepare and place orthodontic bands, brackets, ligatures and etc. on a patient's teeth to include the placement of orthodontic separators.
- Surgical orthodontics incidental to orthodontic treatment, to include the extraction of non-symptomatic teeth (sometimes referred to as "serial extractions" of pre-molars and molars), the surgical placement of implant anchors, "bollard plates" to "distract" the growth or trajectory (direction) of the upper or lower jaws, exposing teeth, exposing the crowns of teeth to aid in the placement of orthodontic brackets, removing remaining deciduous teeth in the dental arches, up-righting a tooth or teeth, etc. The DPA will make the final determination on what constitutes "surgical orthodontics."
- Surgically assisted rapid palatal expansion (SARPE) procedures to treat transverse jaw issues or a high-narrow palate if the maxilla does not meet the criteria outlined under the Orthognathic Surgery Medical Policy of Blue Shield for transverse discrepancies.
- Surgical treatment to expose impacted teeth, surgical placement of tooth collars, or procedures to direct the eruption of teeth.
- Treatment to remove orthodontic cement from teeth, discoloration of teeth and periodontal or gingival surgery to expose the clinical crown(s) of teeth for the purpose of attaching an orthodontic bracket to the tooth.
- Treatment for myofunctional or myofascial therapy as part of an orthodontic treatment program.
- Changes in treatment necessitated by an accident.
- Re-treatment of orthodontic cases when the DPA concurs with the professional judgment of the attending dentist of a poor prognosis.
- Relapse of the occlusion or movement of teeth to their original position after primary orthodontic treatment is completed.
- Treatment for temporomandibular joint (TMJ) disorder (or dysfunction), bruxism or clenching of the teeth as the result of orthodontic treatment.

Benefit Exclusions *(cont'd.)*

- Special orthodontic appliances, including but not limited to, lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic.
- X-rays for orthodontic purposes (to include full mouth screen, 3-dimensional radiographs, rendering of 3-dimensionl images, and cephalometrics) - Dental - Blue Shield HMO Plans (DHMO).
- Replacement of lost, broken, or stolen appliances (e.g., orthodontic retainers) or repair of the same if broken.
- Charges for records fee to include but not limited to cephalometric tracing, photos, models, radiographs (initial, progressive, and final, as deemed necessary), 3-dimensional cone beam computerized tomography (CBCT), and computerized-digital modeling of the jaws and face.
- Interceptive orthodontics or "preventive-orthodontics" of any sort (sometimes referred to as "Phase One" orthodontic treatment) to the deciduous and/or transitional dentition.
- Orthodontic treatment for patients with deciduous and or transitional dentition retained in the patient's mouth.
- Orthodontic treatment using a removable or fixed orthodontic appliance to achieve a limited cosmetic result (for example moving a single anterior tooth because it is positioned too far back in the mouth).
- Charges for broken or missed appointments.
- Appliances constructed to prevent a future malocclusion from developing. For example, a "thumb-sucking" device to prevent the patient from sucking the thumb and causing flaring of the front teeth.
- Treatment which is received in more than one course of treatment, or which is not received in consecutive months or treatment exceeding 24 months (for example, stopping approved orthodontic treatment then later returning to re-start orthodontic treatment).
- Any self-prescribed orthodontic treatment (orthodontic aligners that can be purchased from the Internet or a pharmacy) unless prior approval has been obtained from the DPA.

Benefit Limitations

Prosthodontics: Existing, lost, or stolen prosthetic devices will be replaced once in the five-year period commencing on the date the appliance was last supplied, whether under this contract or any prior dental care policy, unless for dental necessity. An "immediate," "remote," "temporary," or "provisional" dentures are viewed as a "denture" (partial, complete, full) and subject to the 5-year replacement guidelines. For example, if a patient elects to have an immediate

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Benefit Limitations *(cont'd.)*

denture made by the attending dentist and then returns to have the immediate denture replaced with a remote denture, Blue Shield will view the immediate denture as the patient's final denture and there will be no replacement of the denture with another denture (remote denture) prior to the five year frequency limitation.

Note: Preparing asymptomatic teeth to support a dental prosthesis is not a benefit. For example, preparing two asymptomatic teeth for crowns to support a fixed dental bridge is not a benefit. In this example, the DPA will authorize a "pontic" to restore the empty space and the Member will be responsible for paying the cost of the two abutment crowns if a fixed bridge solution is pursued. Alternatively, an appropriate partial denture to restore the empty tooth space will be approved.

Partial Dentures: If a satisfactory result can be achieved by a standard cast chrome-resin partial denture, but the member and dentist select a more complicated precision appliance, or the use of special materials, or "flexible-esthetic" materials (e.g., "Valplast" partial dentures), the financial obligation of the DHMO plan will be for those procedures necessary to eliminate oral disease and restore missing teeth in the most cost efficient manner. The balance of the cost will remain the responsibility of the member.

Complete ("full") Dentures: If a satisfactory result can be achieved through the utilization of standard procedures and materials, and the member and the Dental Provider select a personalized appliance or one involving specialized techniques, or the use of special materials, or "flexible-esthetic" materials (e.g., "Valplast" partial dentures), the financial obligation of the DHMO plan will be any of the procedures necessary to eliminate oral disease and restore missing teeth in the most cost efficient manner. The balance of the cost will remain the responsibility of the member.

Dental prophylaxis: Dental prophylaxis (dental cleanings) are available not more than once in any period of 6 consecutive months. Prophylaxes performed in conjunction with fluoridation or any other periodontal procedure (e.g., gross debridement of tartar from teeth) shall be considered a dental prophylaxis for the purpose of applying this limitation. A dental prophylaxis should not be confused with a periodontal prophylaxis (also known as a "deep cleaning" or "subgingival curettage and root planning" procedure) which has a different treatment goal. The treatment goal of a dental prophylaxis is the mechanical removal of oral-dental debris, tartar (calculus) and stains on the teeth that project above the gum line primarily for cosmetic considerations; it is usually performed without the use of an anesthetic.

Endodontics: Root canal (endodontic) treatment includes pulp capping; therapeutic pulpotomy on deciduous teeth only (in addition to restoration); apexification; root canals on permanent teeth only, including pulpotomy or other palliative treatment and necessary x-rays, and apicoectomy (including apical curettage), but excluding the final restoration of the tooth. Documentation

Benefit Limitations *(cont'd.)*

requires the submission of pre- and post-operative radiographs clearly showing the apex of the treated tooth. The endodontic filling must meet current endodontic treatment guidelines (a three-dimensional root canal filling that is +/- 1.5 mm of the apex per UCSF-School of Dentistry Guidelines).

Palliative: This is emergency treatment for immediate relief of acute, intractable (severe) oral or tooth pain or the medical stabilization of the teeth or oral structures (not the definitive treatment or restoration of the dentition). For example, if a cusp is fractured on a tooth and there are "sharp edges that lacerate the soft tissues of the mouth, the "palliative" treatment is to smooth off the sharp edges of the tooth, not requesting a crown for the tooth (this is definitive treatment). Documentation requires submission of necessary pre- and post-radiographs and written documentation.

Periodontics: Periodontal (gum) treatment is available to treat emergency periodontal problems, periodontal abscess, and acute/chronic periodontitis.; Treatments include root planning (not dental prophylaxis); subgingival curettage, debridement, gingival and osseous surgery (including post-surgical visits). All periodontal surgery must be medically or dentally necessary and must meet Blue Shield guidelines of gingival pocket depths, root exposure, jawbone recession around the teeth, and a fair to good long-term prognosis. There must be radiographic evidence that there is sufficient exposed root surfaces and root calculus to accomplish the treatment goals associated with "root planning" of the roots of the tooth/teeth. A "periodontal prophylaxis" ("deep cleaning" or subgingival curettage-root planning) is limited to once in 24 months per quadrant of teeth. Periodontal prophylaxis should not be confused with routine "dental prophylaxis" or "dental cleaning" which has a very limited "cosmetic" treatment goal.

Note: The so-called "deep cleaning" (subgingival curettage and root planning or periodontal prophylaxis) is considered a definitive surgical treatment modality for moderate to severe periodontal conditions ("Community Periodontal Index and Treatment Needs" or CPITN levels III, IV). It is recommended the member direct the participating dentist to obtain pre-certification for such a procedure by submitting a full set of current radiographs, bitewing radiographs, a complete periodontal pocket charting and any intra-oral photographs, as needed, to document the dental necessity for a "deep cleaning" to the DPA. Per utilization management guidelines, only 2 quadrants of the mouth can be treated in one (1) appointment and a local anesthesia must be utilized. For a "deep cleaning" to be authorized, the DPA will determine if there are periodontal pockets greater than 4 mm, there are sufficiently exposed root surfaces of the teeth to allow for the planning of the root surfaces per the code definition and if there is radiographic calculus visible on the root surfaces. A deep cleaning should not be confused with a "dental cleaning (dental prophylaxis)." The treatment goals of a "dental cleaning" are to remove stains and supragingival tartar (calculus) from the teeth primarily for cosmetic considerations and not necessarily to treat "gum disease" (i.e., a dental cleaning is for a CPITN 0, I, II). If the attending

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Benefit Limitations *(cont'd.)*

dentist makes a diagnose the member has "healthy gums," a "deep cleaning" is not needed, and payment will be denied.

Note: Gum (soft tissue) surgery to cover exposed roots, exposed margins of crowns, implant screws and etc. are generally considered cosmetic procedures and therefore are generally not a benefit of the Dental Plan.

Oral Surgery: Extractions; removal of symptomatic (painful, infected) impacted teeth (not for any orthodontic considerations), radical excision of small (to 1.25 cm) non-malignant lesions; other surgical procedures; includes local anesthesia and routine pre- and post-operative care. Removal of deciduous teeth that are within 6 months of natural exfoliation are not a covered benefit (adjudication by the Dental Plan Administrator). All oral surgery must be medically necessary. All ancillary procedures associated with the initial surgery are considered integral to the surgery and not separate billable procedures (sutures, follow-up treatments, removal of sutures, treatment for surgical complications, insertion of drains, prescriptions, bone fillers, post treatment materials, local anesthesia, etc.).

Note: Bone grafts to fill-in the empty tooth socket after tooth removal must be medically necessary. Bone grafts do not accelerate tooth socket healing, does not make the healing more comfortable, and does not necessarily prevent the atrophy of the edentulous space.

Note: Certain routine oral surgery procedures to include extractions of teeth have specific limitations to include age limitations per the Blue Shield of California (Blue Shield) Utilization Guidelines. Before having any oral surgical procedures and/or extractions performed, the provider (and member) is strongly advised to request pre-authorization of any oral surgery procedures. Failure to obtain a pre-authorization for any oral surgery or extraction procedures from Blue Shield will result in the strict adjudication of the surgical procedure(s) per Blue Shield Utilization Guidelines (sometimes referred to as the Blue Shield "Utilization Management Matrix").

Restorative Dentistry ("fillings"): Amalgam restorations and synthetic restorations (e.g., porcelain filling, plastic filling, and composite filling).

Note: Stainless steel crowns are used when the tooth cannot be restored with a direct filling material (stainless steel crowns, when properly prepared, are considered permanent restorations per the United States Department of Veterans Administration and subject to the 5 (five) year frequency limitations).

Orthodontic Services: If a particular Dental Plan provides for "medically necessary" orthodontics, the Member must score "26" on the State of California Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet (DC016) or have an "automatically qualifying" condition (clinical documentation to include radiographs and photographs must be provided for review) to be eligible for orthodontic care.

Benefit Limitations *(cont'd.)*

Waiting Period: A request to waive the mandatory "waiting period" for a bonified dental emergency and/or when there is acute, intractable (severe) dental or oral pain may be requested when the provider submits clinical information as to the nature of the dental or oral problem (clinical note written on office letterhead, radiographs, intra-oral photographs, etc.) and the reason why such a treatment waiver is justified. A member calling a "customer service representative" stating that they are "in pain," is insufficient clinical information to consider waiving the mandatory "waiting period" for a particular dental service. The treatment goal, when waiving the mandatory "waiting period" for a particular dental procedure, is the immediate relief of pain or to provide emergency dental services to medically or dentally stabilize an emergency condition; it is not necessarily to restore the dentition or to provide definitive treatment. Requests to waive the waiting period for crowns, fillings, gum surgery, orthodontic care, etc. will be denied.

Indirect Restorations: Non-precious metal crowns are generally specified for posterior teeth; porcelain fused to nonprecious metal restorations (crowns) are generally reserved for anterior teeth or when dental esthetics is a consideration. For crowns, a five-year frequency replacement period will start from the date the existing crown was last seated on the tooth or supplied, whether under this contract or under any prior dental care policy or Plan and must be dentally/medically necessary. Full ceramic, porcelain, ceramic-porcelain crowns are considered cosmetic procedures for anterior and posterior teeth; reimbursement will be at the same level as the appropriate metal or porcelain-non-precious metal crown for the tooth. The balance of the cost for such crowns will remain the responsibility of the member.

Note: Cast "inlays" (metal, ceramic, resin) will be reimbursed for the equivalent direct restoration ("fillings").

Note: Core build-up of the tooth is a benefit when used to increase the surface area of the tooth to retain a dental crown. For the purpose of this Plan, a "core" build-up is not defined as a procedure to fill-in undercuts in the crown preparation or fill-in small holes or gaps in the dental crown preparation. Core build-ups should not be confused with a "pulp-capping" procedure; in this case a sedative dental material is placed in a tooth when there is a pulpal exposure or the possibility of a pulpal exposure.

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Benefit Limitations *(cont'd.)*

Direct Restorations ("fillings"): Amalgam material is generally specified to restore posterior teeth; composite or plastic materials are used to restore anterior teeth. Judgement for materials used will be between the Member and the Dental Provider providing the covered service. The use of composite or plastic materials on posterior teeth will be paid at the same level as the comparable amalgam restoration; the balance of the cost will remain the responsibility of the member. If the Member's specific Dental Plan provides for posterior composite fillings as a benefit, then the DPA will not substitute the "alternative benefit" of an amalgam filling for a posterior tooth.

Note: Direct dental restorations are dental materials placed directly into a tooth preparation usually after removal of pathology (dental caries) or a tooth is to be restored due to an insult (e.g., fracture). Typical direct fillings materials are silver amalgam, resin fillings (composites), various types of dental cements, and gold foil. In most Blue Shield Dental Plans, silver amalgam is specified for posterior teeth (molars and premolars). Anterior teeth are usually restored with a resin material ("white fillings"). Some Blue Shield plans do not specify the type of dental filling material to be used to restore teeth. If there is a question as to the type of filling materials specified for a tooth, the provider is encouraged to request a pre-authorization of their treatment plan for their patient. Generally, resin fillings are expected to remain serviceable for 18 months from initial installation. Silver amalgams are expected to remain serviceable for 48 months after they are installed.

Note: Pulp capping and basing materials are integral and incidental to all direct filling procedures. They are not considered "core build-up" procedures.

Note: The term "serviceable" as used in the forementioned policy is defined as: No cracking or fractures of the dental material and no tooth-dental material voids. Discolored fillings, fillings with worn anatomy do not make a filling unserviceable.

Full Mouth Rehabilitation: If the member and the attending dentist select a course of full mouth rehabilitation, the obligation of the DHMO plan will be to cover only those benefits appropriate to those procedures necessary to eliminate oral disease and replace missing teeth in the most cost-efficient manner. The balance of the treatment, including costs to increase vertical dimension of the occlusion, improve esthetics or cosmetics, or to restore tooth loss by attrition or erosion, will remain the responsibility of the member.

Benefit Limitations *(cont'd.)*

Pedodontics: Referral of dependent children to a children's dentist (pedodontist) will be covered by the DHMO plan for children up to, but not beyond 6 years old, with prior approval. Benefits are not applicable for pediatric dental care provided by a plan specialist for children age 6 and over unless for clinically documented dental or medical necessity, or the child will not allow the general dentist to treat after two attempts (the provider must provide thorough clinical documentation, not just a note that states the "patient is uncooperative"). All such exceptions must be approved by the DPA (the DPA will adjudicate the treatment request for pediatric dental specialist services based on the training and reasonable treatment expectations of the scope of practice provided by general dentists practicing in the United States and Canada).

Note: Requests to obtain treatment from an "out-of-network" pediatric (or any) dental specialist because of personality or logistical issues (i.e., the parents do not "like" the "in-network" pediatric dental specialist or because the "drive is too far" to the "in-network" specialist) are not considered sufficient clinical rationale to allow the member to request services of a specialist outside the network.

Implants: Single cylinder implants are a benefit only when Plan criteria are met. Not a benefit are implants used to directly or indirectly support dentures, implants used as an abutment for a fixed dental bridge, when there are empty (edentulous) teeth spaces on both sides of the same dental arch ("bilateral edentulous spaces"), lower anterior teeth (teeth 22, 23, 24, 25, 26, 27), second molars (teeth 2, 15, 18, 31), third molars (teeth 1, 16, 17 and 32), when there is no opposing tooth/teeth, the tooth space is too small to accommodate a normal size tooth, and when the implant is not the initial replacement for a missing tooth. Depending on the Plan, the abutment (the metal screw that goes into the implant screw that supports the crown) for an implant is considered an integral part of the implant screw and not a separate billable item or procedure. Implant procedures such as mounting diagnostic casts on an articulator, special implant surgical guides, uncovering the implant, temporary crowns utilized in the "immediate loading" technique, temporary appliances to cosmetically cover a missing tooth while the implant heals, special manipulation or renderings of radiographs, extra or intra oral photographs, and three-dimensional radiographs are generally not a benefit of this Plan.

Dental - Blue Shield HMO Plans (DHMO)

Benefit Limitations *(cont'd.)*

Emergency Claims: The DHMO plan's liability for emergency services rendered outside of the service area will be limited to $50 in palliative treatment services only. If emergency services outside of the service area were received and expenses were incurred by the member, the member must submit a complete claim with the emergency service record, to include pre-accident or pre-trauma radiographs, (a copy of the dentist's bill) for payment to the DPA within one year after the treatment date. Claims should be sent to:

Blue Shield of California
P.O. Box 30567
Salt Lake City, UT 84130-0567

If the claim is not submitted within this period, the DHMO plan will not pay for those emergency services unless the claim was submitted as soon as reasonably possible as determined by the plan. If the services are not pre-authorized, the DPA will review the claim retrospectively.

References

Combined Evidence of Coverage and Disclosure Form Blue Shield of California Dental HMO Supplement.

Blue Shield of California Utilization Management Matrix