

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage

Benefits are provided for services performed by licensed dentists and oral surgeons for treatment of teeth, jaws, and their dependent tissues.

The member is responsible for assuring that the dentist chosen is a participating dentist. The member is also responsible for following the Precertification of Dental Benefits Program which includes obtaining or assuring that the participating or non-participating dentist obtains Precertification of Benefits.

Before any course of treatment expected to cost more than \$250 is started, the member should obtain Precertification of Benefits. The dentist should submit the recommended treatment plan and fees together with appropriate diagnostic x-rays to Blue Shield's Dental Plan Administrator (DPA) at:

Dental Benefits Providers of California, Inc.
425 Market Street, 12th Floor
San Francisco, CA 94105

The dental plan provides benefits for covered services at the most cost-effective level of care that is consistent with professionally recognized standards of care. If there are two or more professionally recognized procedures for treatment of a dental condition, this plan will in most cases provide benefits based on the most cost-effective procedure. The benefits provided under this plan are based on these considerations but the member and the dentist makes the final decision regarding treatment.

Services exceeding \$250 are subject to pre-certification by Blue Shield.

Failure to obtain pre-certification of benefits will not necessarily result in denial of benefits. If the pre-certification process is not followed, the DPA will still determine payment by taking into account alternative procedures, services or materials for the dental condition based upon professionally recognized standards of practice. The covered dental expense will be limited to the allowed amount for the procedures which meets professionally recognized standards and is the most cost effective as determined by the DPA.

Principal Benefits and Coverages:

The following services are benefits when provided by a dentist and when necessary and customary as determined by the standards of generally accepted dental practice. These benefits are subject to the terms, conditions, limitations and exclusions of the plan.

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Benefit Coverage *(cont'd.)*

Diagnostic and Preventive Services:

- Clinical oral examinations including consultations by a specialist (if diagnostic service is provided by a dentist or physician other than the practitioner providing treatment), not more than once in any period of 6 consecutive months.
- Dental prophylaxis not more than once in any period of 6 consecutive months. (Prophylaxes performed in conjunction with fluoridation or any other procedure, and periodontal prophylaxes shall be considered as being a prophylaxis for the purpose of applying this limitation.)
- Topical application of fluoride not more frequently than once in any period of 12 consecutive months and only for eligible persons under the age of 18 except when dental necessity is established with submission of the “caries management by risk assessment” (CAMBRA) protocol tool.
- Dental and periodontal prophylaxis (recall or maintenance visit) not more than a combined total of one periodontal and/or regular prophylaxis per each period of 6 consecutive months.
- X-rays:
 - Bitewing film not more than once in any period of 6 consecutive months. Full mouth series (includes 10 to 14 periapical x-rays and supplementary bitewing films) not more than once in any period of 24 consecutive months. In applying this 24 month limitation, a panoramic x-ray shall be considered a full mouth series.
 - X-rays required to diagnose a specific condition that needs treatment are not subject to limitations stated above.
- Diagnostic casts not more than once in any period of 24 consecutive months to evaluate the occlusion (bite). If the diagnostic casts are taken as part of the records preparing for orthodontic treatment, the casts will be covered under the lifetime orthodontic benefit. Working models taken in conjunction with a prosthetic, sleep apnea, temporomandibular joint, dental implants, or other appliance(s) are not considered to be diagnostic casts.

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Benefit Coverage *(cont'd.)*

Basic Services:

- Anesthesia – General, intravenous sedation, oral conscious sedation, and nitrous oxide analgesia only when provided in conjunction with a covered oral surgical procedure and consistent with the Blue Shield Basic Dental Plan criteria for the employment of this treatment modality.
- Endodontics – 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 culture; and apicoectomy (including apical curettage), but excluding the final restoration of the tooth. Documentation requires the submission of pre- and post-operative radiographs clearly showing the apex of the treated tooth.
- Oral Surgery – Extractions; removal of symptomatic impacted teeth (not for 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 exfoliate is not a covered benefit; 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, insertion of drains, prescriptions, bone fillers, post treatment materials, local anesthesia, etc.).
- Palliative – Emergency treatment for relief of pain (not the definitive treatment of the dental pain). Documentation requires submission of necessary pre- and post-radiographs and written documentation.
- Periodontics – Emergency treatment including but not limited to periodontal abscess and acute periodontitis; root planing (not prophylaxis); subgingival curettage, debridement, gingival and osseous surgery (including post-surgical visits). All periodontal surgery must meet BSC guidelines of gingival pocket depths, root exposure, jaw bone recession around the teeth, and a fair to good long-term prognosis.
- Restorative Dentistry – Amalgam restorations and synthetic restorations (e.g., porcelain filling, plastic filling, and composite filling). Stainless steel crowns are used when the tooth cannot be restored with a direct filling material.
- Sealants – One treatment in any period of 24 consecutive months per each permanent molar, and only for patients under age 18.

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Benefit Coverage *(cont'd.)*

- Space Maintainers – Includes all adjustments within 6 months after the installation. Benefits for space maintainers are limited to eligible dependent children under age 16. Removal of a space maintainer is integral to the placement of the appliance.

Major Services:

- Cast Restorations – Cast or other laboratory prepared restorations and crowns are covered only when teeth cannot be restored with a direct filling material. Cast restorations consists of full cast metal crowns, inlays, veneers or onlays constructed of precious metal, dental casting metal, acrylic, composite-glass, porcelain, and porcelain-fused to metal inlays. Post-cores and crown build-ups are used on vital or non-vital teeth when functionally necessary to help to retain a crown. There is no coverage for replacement of an existing crown, inlay or onlay, or other cast restoration which is less than 5 years old and/or can be repaired. Repair or re-cementing on inlays, onlays and crowns is covered for 6 months after installation.
- Prosthetics – Bridges, dentures, partials and relining or rebasing dentures, adding teeth to an existing partial denture to replace extracted teeth, full and partial denture repairs, stayplate, special tissue conditioning per denture (limited to one course of treatment per 6-month period), and denture duplication (jump case). Fees for appliances include adjustments, repairs, and relines for a 6-month period following installation. An additional benefit for one reline per immediate denture is payable during the first 6 months following installation. Replacement of an existing partial denture which is more than 5 years old and cannot be repaired will normally be limited to a new partial denture. Upgrading from a partial denture to fixed bridgework will be payable only if acceptable documentation is presented which clearly demonstrates that the patient's arch cannot be adequately restored with a partial denture. A removable dental prosthesis, regardless of type, (immediate, remote, provisional, temporary, complete or partial), is regarded as a "denture" and subject to the 5-year replacement provision.
- Dental Implants – Depending on the Plan, dental implants may be a benefit; if a Plan authorizes implants as a benefit, then strict adherence to Plan utilization guidelines and criteria must be met.

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All services for covered benefits are administered by Blue Shield's Dental Plan Administrator (DPA). Participating Dentists have agreed to accept the DPA's payment, plus any applicable deductible and copayment, as payment in full for covered services. This is not true of non-participating dentists.

The Blue Shield of California Smile *Basic* Dental Plan reduces coverage for services provided by non-participating dentists. Assignment of benefits to non-participating dentists is not allowed.

Applicable deductibles, copayments and charges in excess of the Allowable Amount by non-participating providers are the responsibility of the member.

Financial Responsibility

The allowable amount is the DPA's allowance for the service(s) rendered, or the provider's billed charge, whichever is less. Payments are based on the allowable amount as defined, and are subject to the dental benefit deductible, the indicated copayment percentages, and all benefit maximums as specified.

Participating Dentists:

- Services rendered for the procedures listed under Diagnostic and Preventive Services are paid at 100% of the allowable amount.
- Services rendered for the procedures listed under Basic Services are paid at 80% of the allowable amount. Subscribers are responsible for the remaining 20% of this amount.
- Services rendered for the procedures listed under Major Services are paid at 50% of the allowable amount. Subscribers are responsible for the remaining 50% of this amount.

Non-Participating Dentists:

- Services rendered for procedures listed under Diagnostic and Preventive Services are paid at 80% of the allowable amount. Subscribers are responsible for the remaining 20% of this amount as well as any charges above the allowable amount.
- Services rendered for procedures listed under Basic Services are paid at 70% of the allowable amount. Subscribers are responsible for the remaining 30% of this amount as well as any charges above the allowable amount.
- Services rendered for procedures listed under Major Services are paid at 50% of the allowable amount. Subscribers are responsible for the remaining 50% of this amount as well as any charges above the allowable amount.

Requests for payment by participating dentists, non-participating dentists, or the subscriber must be submitted to the DPA within 6 months after the month in which services were provided.

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Copayment and Deductible Amounts

A calendar year deductible of \$75 per person is applied as follows:

- The deductible applies to all covered services and supplies furnished by participating and non-participating dentists. The deductible applies separately to each covered person each calendar year.
- The maximum deductible required for services by any combination of participating and non-participating dentists is \$50 per person, not to exceed \$150 per family, each calendar year.
- Diagnostic and preventive services provided by participating dentists are not subject to deductible.

The Blue Shield of California Smile Basic Dental Plan pays up to a maximum of \$1000 per person each calendar year for covered services and supplies provided by participating dentists, and a maximum of \$750 per person per calendar year for covered services and supplies provided by non-participating dentists. The maximum payment each calendar year for covered services and supplies by any combination of participating and non-participating dentists is \$1000 per person. (This maximum is not applicable to Orthodontic Services if a benefit.)

Benefit Limitations

- Implants – Dental implants including any artificial materials, natural or synthetic bone grafting materials or soft tissue grafting materials which are implanted into, onto, or under bone or soft tissue, or the removal of implants (surgically or otherwise) are not a benefit unless **specified** in the Plan. Depending on the Plan, the implant abutment is generally considered an integral part of the implant screw and not a separate billable procedure. If an implant procedure is performed, without prior authorization from Blue Shield of California, the DPA or Blue Shield of California may pay the benefit available for any conventional restorative prosthetic procedure (if any) which could have been used to correct the subscriber's condition in a professionally satisfactory and/or least cost alternative manner. If the DPA or Blue Shield of California makes an allowance toward the cost of an implant procedure(s), benefits will not be available for any replacement prosthesis placed within the immediately following 5 years.
- Regardless if a Plan has dental implants as a benefit, dental implants are not provided under the following criteria: 1) Lower anterior teeth (teeth 22, 23, 24, 25, 26, 27), second molars (teeth 2, 15, 18, 31), 3) third molars (teeth 1, 16, 17, 18), 4) when there are empty tooth/teeth spaces on both sides of the same dental arch (jaw), 5) when there is no opposing tooth/teeth, 6) when the tooth space is too small to accommodate a normal size tooth, 7) to support (directly or indirectly) any sort of denture, 8) serve as an abutment for a fixed dental bridge, and 9) when the dental implant is **NOT** the initial replacement for the missing tooth.

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Benefit Limitations *(cont'd.)*

- Crowns/Inlays – Benefits are not provided for crowns, inlays or onlays, laminate veneers, or other cast or laboratory prepared restorations if the tooth can be restored with a direct filling material (e.g., amalgam, composite resin, or silicate cement). Typically, a tooth must be missing 2 cusps and 3 surfaces to warrant a crown. Cracks visible in the enamel of the tooth, defective fillings, or large “cavities,” are, in-of- themselves, insufficient clinical rationale for a crown.
- General Anesthesia – Benefits are not provided for general anesthesia or intravenous sedation except as administered by a licensed dentist in connection with a covered oral surgical procedure per Plan utilization guidelines. Not covered are the services of “mobile dental anesthesia teams” that provide various sedation services in dental offices.

Benefit Exclusions

Unless exceptions to the following general exclusions are specifically made elsewhere under these plans, Blue Shield of California Smile Basic Dental Plan does not provide benefits with respect to:

- Charges for services in connection with any treatment to the gums or hard tissues for tumors, cysts and neoplasms.
- Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if the DPA or Blue Shield of California provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by the DPA or Blue Shield of California for the treatment of such injury or disease.
- Charges for vestibuloplasty (i.e., surgical modification of the jaw, gums, and adjacent tissues) in preparation to construct a denture.
- Any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural or skeletal disorder, dysfunction, or disease of the temporomandibular (jaw hinge) joint and its associated structures, including but not limited to myofascial pain dysfunction syndrome.
- Charges for treatments to augment the dental ridges due to the natural aging process (jaw atrophy) in preparation for a denture (partial or full).
- Any surgery in preparation to place a dental implant (e.g., “sinus lift” procedure).
- Charges for services performed by a close relative or by a person who ordinarily resides in the subscriber's or dependent's home.

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Benefit Exclusions (*cont'd.*)

- Services or supplies provided in connection with a congenital anomaly (an abnormality present at birth) or developmental malformation (an abnormality which develops after birth). Congenital anomalies and developmental malformation include but are not limited to cleft palate, cleft lip, upper or lower jaw malformations (e.g., prognathism), enamel hypoplasia (defective development), fluorosis (a type of enamel discoloration), treatment involving or required by supernumerary teeth; and anodontia (congenitally missing teeth).
- Charges related to prescribed drugs or locally delivered drugs, pre-medication, analgesia, local anesthetics, sedatives, or periodontal pocket irrigation.
- Dental treatment when the mandatory “waiting period” has not been met for a dental treatment.
- Services, procedures, or supplies which are not reasonably necessary for the care of the person’s dental condition according to broadly accepted standards of professional care or which are investigational in nature or which do not have uniform professional endorsement.
- Appliances, restorations or services, including but not limited to occlusal equilibration required solely to change, maintain or restore the vertical dimension of occlusion.
- Re-positioning the temporomandibular joints (jaw joints) or “re-capturing” the articulating disc of the TMJ fossa.
- Splinting loose teeth (i.e., stabilizing periodontally loose teeth).
- Services, procedures or supplies which are purely cosmetic in nature. White facings on crowns or pontics posterior to the second bicuspid, and composite restorations on posterior teeth, shall always be considered cosmetic. If “white fillings” are placed on posterior teeth, most Plans will reimburse the provider for the equivalent “silver filling.”
- The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) which has been lost, damaged or stolen.
- Myofunctional therapy, athletic mouthguards, precision or semi-precision attachments, denture duplication, oral hygiene instruction, treatment of jaw fractures, sealants (over age 18), enamelplasty to prevent caries (cavities), oral habit devices, and charges for acid etching.
- Charges for saliva testing, caries testing, blood tests, diabetes tests, and virus testing.
- Charges for three dimensional radiographs.

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Benefit Exclusions *(cont'd.)*

- Orthognathic surgery, including but not limited to osteotomy, ostectomy, and other services or supplies to augment, re-position or reduce the upper or lower jaw to correct a skeletal discrepancy.
- Charges for surgical services in connection with orthodontia, except those listed under covered services.
- Temporary dental services. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable.
- Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues).
- Bone or soft tissue grafts to fill-in a tooth socket after an extraction.
- Bone grafts around dental implants.
- Hospital costs and any additional fees charged by the dentist for hospital treatment.
- Surgical services, treatments and/or oral appliances constructed by a dentist for the treatment and/or management of obstructive sleep apnea.
- Any service, procedure, or supply for which the prognosis for long-term success is not reasonably favorable, as determined by the DPA and its dental consultants.
- For which the person is not legally obligated to pay, or for services for which no charge is made to the person.
- Any service, procedure, or supply which is received or started 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 started 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 date the pulp chamber is opened;
 - For periodontal surgery: on the date the surgery is actually performed;
 - For all other services: on the date the service is performed.

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References

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