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.
- 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.

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 of dental necessity.

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.

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Copayment

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

When the member and dentist opt to select a 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.
- Dental treatment that has been previously started by another dentist prior to the participant's eligibility to receive benefits under this plan.
- Dental services for cosmetic purposes (e.g., bleaching, veneer facings, crowns; porcelain on molar crowns, or brides and/or dentures).
- Dental services performed in a hospital or any related hospital fee.
- Treatment to correct congenital and developmental malformations including but not limited to: cleft palate, anodontia, mandibular prognathism, enamel hypoplasia, enamel dysplasia, enamel discolorations, and malocclusions caused by skeletal jaw discrepancies.
- Treatments which, in the professional judgement of the DPA, have a poor prognosis when an alternative treatment with a more favorable prognosis is available.
- 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.

Benefit Exclusions *(cont'd.)*

- 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, except;
    - When such reimbursement is expressly by the DHMO plan; or
    - As cited under the Emergency Services and Emergency Claims provision.
- Treatment for any condition for which benefits could be recovered under any worker's compensation or occupational disease law, when no claim is made for such benefits.
- Treatment for which payment is made by any governmental agency, including any foreign government.
- Treatment from dentists outside the United States of America except when emergency services are medically necessary to 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.
- Temporomandibular Joint (TMJ) disorder or dysfunction to include any referred pain to the jaw joints, trismus, discomfort to the muscles of mastication.
- Any oral-myofacial 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, ridge augmentations, bone grafts to the dental implant site, periodontal procedures to 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.
- General anesthesia including intravenous, conscious (oral route) and inhalation 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 condition, and (c) not furnished primarily for the convenience of the patient, the attending dentist or other provider, and not provided because of dental phobias, combativeness, and non-cooperation of the patient.

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Benefit Exclusions *(cont'd.)*

- Written documentation of the medical condition necessitating use of general anesthesia or intravenous or inhalation sedation must be provided by a physician (M.D.) to the Dental Center. Written documentation on the medical condition of a patient from a dentist requesting medically necessity sedation services is not acceptable.
- Patient apprehension or patient anxiety will not constitute medical necessity.
- 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.
- The DHMO plan reserves the right to review the use of general anesthesia to determine dental necessity.
- Charges for broken or missed appointments.
- Prophylaxis more than twice per calendar year.
- Precious metals (if used, will be charged to the patient at the dentist's cost).
- 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, whether under this contract or any prior dental care policy, unless of dental necessity.
- Removal of 3rd molar (wisdom teeth) other than for dental necessity (pain, swelling, 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 is not medically necessary.
- Referral of a dependent child age 6 and over to a pedodontist (specialist in children's dentistry), unless for dental necessity, or the child is uncooperative and will not allow the general dentist to treat after two attempts. 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 accidental coverage.
- Services, procedures, or supplies which are not reasonably necessary for the care and maintenance of the member's dental condition according to the broadly accepted standards of professional care or which are experimental or investigational in nature or which do not have uniform professional endorsement.
- Dental treatment that does not meet Plan "utilization" guidelines, when the mandatory "waiting period" for specified dental services have not been met.

Benefit Exclusions *(cont'd.)*

Orthodontic Exclusions:

- Treatment in progress (after banding) at inception of eligibility.
- Surgical orthodontics (including extraction of teeth) incidental to orthodontic treatment to include to include the surgical placement of implant anchors or "bollard plates," to "distract" the growth or direction of the upper or lower jaws.
- 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 policy 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 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 that there is a poor prognosis.
- Treatment for Temporomandibular joint (TMJ) disorder (or dysfunction), bruxism or clenching of the teeth as the result of orthodontic treatment.
- 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 and cephalometrics) - Dental - Blue Shield HMO Plans (DHMO).
- Replacement of lost or stolen appliances (e.g., orthodontic retainers) or repair of 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).

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Benefit Exclusions *(cont'd.)*

- Orthodontic treatment for patients with any deciduous teeth still 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.

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 of 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 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.

Partial Dentures: If a satisfactory result can be achieved by a cast chrome partial denture, but the member and dentist select a more complicated precision case, the obligation of the DHMO plan will be any of the benefits appropriate to those procedures necessary to eliminate oral disease and restore missing teeth. 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 if the member and the Dental Provider select a personalized appliance or one involving specialized techniques, the obligation of the DHMO plan will be any of the procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost will remain the responsibility of the member.

Benefit Limitations *(cont'd.)*

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 period will be measured from the date the existing crown was last supplied, whether under this contract or under any prior dental care policy. 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 crown for the tooth. The balance of the cost for such crowns will remain the responsibility of the member.

Direct Restorations: 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 solely that of the Dental Provider providing the covered service. The use of composite or plastic materials on posterior teeth will be at the same level as the comparable amalgam restoration; the balance of the cost will remain the responsibility of the member.

Full Mouth Rehabilitation: If the member and the Dental Center select a course of 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. The balance of the treatment, including costs to increase vertical dimension of the occlusion, or to restore tooth loss by attrition or erosion, will remain the responsibility of the member.

Pedodontics: Referral of dependent children to a pedodontist will be covered by the DHMO plan for children through age 5 with prior approval. Benefits are not applicable for pedodontic care provided by a plan specialist for children age 6 and over unless of dental necessity, or the child will not allow the general dentist to treat after two attempts. All such exceptions must be approved by the plan.

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 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, special manipulation or renderings of radiographs, extra or intra oral photographs, and three-dimensional radiographs are generally not a benefit of this Plan.

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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:

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

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.