Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage

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

The member is solely responsible for assuring that the dentist chosen is a participating dentist. The member is also solely responsible for following the precertification of Dental Benefits Program which includes directing the participating or non-participating dentist to request and obtain precertification of ALL benefits prior to the initiation of any dental treatment.

Before any course of treatment expected to cost more than $250 is started, the member is advised to 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 (in the United States and Canada). If there are two or more professionally recognized procedures for treatment of a dental condition, this Plan will generally provide benefits based on the most cost-effective procedure to restore the function of the tooth, teeth and oral cavity. The benefits provided under this plan are based on these considerations but the member and the attending 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.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage *(cont'd.)*

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.

Note: The *Evidence of Coverage*, *DPPO Benefit Guidelines*, and the *Summary of Benefits* are not designed to cover ALL of the various specific Plan benefits, exclusions, limitations, medical-dental treatment rationale and restrictions. In the event there is a question if a particular dental treatment or service is a benefit, Blue Shield 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: 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 as to whether or not a specific procedure or treatment falls into the "dental" category or "medical" category, the DPA 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 DPA from the attending dentist.

Diagnostic and Preventive Services:

Clinical oral examinations: 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: 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).

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 available from the American Dental Association Website.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage *(cont'd.)*

Periodontal Services: Periodontal (gum) treatments are available to treat periodontal problems, for emergency periodontal problems, including but not limited to, periodontal abscess, acute periodontitis; root planning-subgingival curettage, periodontal debridement for certain medical problems or medication usage, gingival and osseous surgery (including post-surgical visits). All periodontal surgery 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 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. Periodontal prophylaxis" ("deep cleaning" or subgingival curettage-root planning) is limited to once in 24 months.

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 (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 is sufficient exposed root surface 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" is to remove stains and supragingival tartar (calculus) from the teeth primarily for cosmetic considerations and not necessarily to treat "gum disease." If the attending dentist makes a diagnose the member has "healthy gums," a "deep cleaning" is not needed, and payment will be denied.

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 (pantomograph) x-ray shall be considered a full mouth series.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage *(cont'd.)*

- X-rays required to diagnose a specific condition that needs treatment are not subject to limitations stated above. Multiple x-rays of the same tooth (or teeth) taken on the same day or over a period of several days may be subject to frequency limitations.

- Three dimensional radiographs or rendering of a 3-dimensional radiograph ("cone beam computerized tomographic radiographs") are not a benefit.

Diagnostic casts: Diagnostic cast are a benefit 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, malocclusion, or other appliance(s) are not considered to be diagnostic casts and are not a benefit.

Basic Services:

Anesthesia: General anesthesia, intravenous sedation, oral conscious sedation, and nitrous oxide analgesia (any medications used to alter mood, the perception of reality and calms patient anxiety will be referred to as "sedation") must be medically necessary and is provided only in conjunction with a covered oral surgical (not routine dental procedures) procedure(s) and consistent with the Blue Shield Basic Dental Plan and the State of California regulations pertaining to the appropriate use of general anesthesia in conjunction with oral surgery treatment. Local anesthesia is considered integral to any dental or oral surgery procedure and is not a separate billable procedure.

Note: Per State of California Regulations, offices employing any manner of sedation must have a facility permit from the California Dental Board indicating the office is medically equipped to provide sedation services, has available emergency medications to manage any sedation emergency and the dental staff are fully trained in sedation procedures. Itinerate (mobile) dental anesthesia teams do not meet the California Regulations for the use of sedative agents in an office not licensed by the State Dental Board for general anesthesia or any sedation services.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage *(cont'd.)*

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. 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). Root canals that do not meet the "standard of care" for the procedure may be deemed to have a "poor prognosis" by the DPA.

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). 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). 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.).

Palliative: This is emergency treatment for immediate relief of acute, intractable (severe) oral or tooth pain or the medical-dental 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.

Restorative Dentistry: Amalgam restorations and synthetic restorations (e.g., porcelain filling, plastic filling, and composite filling). Stainless steel crowns are used when the deciduous 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. The use of "tooth-colored facings" on stainless steel crowns, prefabricated ceramic crowns, and resin crowns will be reimbursed at the equivalent rate for a stainless steel crown with no facings or coverings.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage *(cont'd.)*

Sealants: One treatment in any period of 24 consecutive months per each permanent molar, and only for patients under age 18.

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 is available 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 INSUFFICENT 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. Generally requests to waive the waiting period for crowns, fillings, gum surgery, deep cleanings, orthodontic extractions of teeth, etc. will be denied.

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 (generally the tooth must be missing a cusp and have three sides of the tooth decayed or restored with a filling). If the DPA determines a tooth can be restored with a direct filling material, the request for a cast restoration will be denied as not dentally necessary. 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 crowns. 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.

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.

Benefit Coverage *(cont'd.)*

Note: Although an existing crown is eligible for replacement after 5 years, the replacement of the crown must be dentally necessary. If the DPA determines the existing crown is serviceable and the rationale for replacement of an existing crown is primarily for esthetic (cosmetic) reasons, the request to replace the crown will be denied.

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, stay plate, 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.

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.

Dental Implants: Depending on the Plan, dental implants may be a benefit; if a Plan authorizes implants as a benefit, strict adherence to Plan utilization management guidelines and criteria must be met (pre-authorization is highly recommended). Restoration of an implant body not pre-approved or authorized by Blue Shield is not a benefit. If the DPA believes an implant will be used to support a denture or a fixed dental bridge, the implant will be denied.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage *(cont'd.)*

Pedodontics: Referral of dependent children to a pedodontist will be covered by the Dental Plan for children up to 6 years of age with prior approval. Services are not a benefit for pediatric dental care provided by a Plan specialist for children age 6 years and over unless for dental necessity and with prior approval, or because the child will not allow the general dentist to treat after two attempts (the provider must provide clinical documentation to include behavioral management techniques employed or attempted, 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 reasonable expectations of the scope of practice and training for general dentists practicing in the United States and Canada). It is the responsibility of the Member to find a Plan pedodontist from the list of specialists provided to them from Blue Shield.

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.

Requests to obtain treatment from an "out-of-network" pediatric (or any) dental specialist because of personality or logistical issues (the parents/patient does not "like" the "in-network" pediatric dental specialist or because the "drive is too far" to the "in-network" specialist) are considered to be insufficient clinical rationale to allow members to request treatment outside the provider network.

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 who are not contracted to accept DPA payments as "payment in full" for dental services; any monetary balances for dental treatment by "out of network" dentists are the responsibility of the member.

The Blue Shield 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.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

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.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

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.

In general, the Blue Shield 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.). The co-pays, deductibles and yearly maximum amounts may vary from Plan to Plan and calendar year. It is best to call the Blue Shield customer service center for further information.

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. Depending on the Plan, if an implant procedure is performed, without prior authorization from Blue Shield, the DPA or Blue Shield 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 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.

Benefit Limitations *(cont'd.)*

If the Plan allows for implants, the restoration of the implant with a permanent restoration is a benefit except if the implant screw was paid by the member without authorization from Blue Shield (self-paid) or paid entirely by another dental plan not associated with Blue Shield.

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 (not routine dental procedures) per Plan utilization guidelines.

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 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 request are not a benefit because the patient 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 or patient cannot "afford to take time off from work 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 patient or child).

The site/office/physical location where general anesthesia, et.al., 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 from the California Dental Board. The use of a mobile dental anesthesia service does not meet this requirement.

Blue Shield frequency limitation for general anesthesia, IV sedation, etc. is 30 minutes per treatment sessions.

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 DPA or Dental Center. Written documentation on the medical condition of a patient from a dentist requesting medically necessary sedation services is not acceptable.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Limitations *(cont'd.)*

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

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 Dental Plan reserves the right to review the use of general anesthesia to determine dental necessity.

Benefit Exclusions

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

- Charges for services in connection with any treatment to the gums (gum surgery) or hard tissues for tumors, cysts and neoplasms.
- Gum surgery to cover exposed roots of teeth as the result of bruxism, age, overzealous or improper brushing of teeth, chemotherapy, radiation therapy, doctor error, accidents, trauma, and etc.
- 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 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 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 myo-facial 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) or implant.
- Any surgery in preparation to place a dental implant (e.g., "sinus lift" procedure).

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Exclusions *(cont'd.)*

- Charges for services performed by a close relative or by a person who ordinarily resides in the subscriber's or dependent's home.
- Any 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/lip, 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. An exception to the mandatory "waiting period" for a bonified dental emergency and/or when there is intractable (severe) oral-dental pain may be requested when the provider submits clinical evidence (clinical note written on office letterhead, radiographs, intra-oral photographs, etc.) that 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 stabilize an emergency dental condition; it is not to restore the dentition.
- Dental treatment that does not meet Plan "utilization" guidelines (solely determined by the Dental Plan Administrator).
- 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 to the Plan).
- 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.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Exclusions *(cont'd.)*

- Re-positioning the temporomandibular joints (jaw joints) or "re-capturing" the articulating disc of the TMJ fossa with an oral appliance.
- 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, retainer, 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), enameloplasty to prevent caries (cavities), oral habit devices, and charges for acid etching.
- Charges for saliva testing, caries testing, blood tests, diabetes tests, virus testing, and testing for the bacterial content of saliva.
- Charges for three dimensional radiographs.
- Any manner of prosthesis used to prevent a temporo-mandibular joint problem from developing (e.g., such as "morning aligners" used in conjunction with oral appliance to manage obstructive sleep apnea).
- Any manner of oral or facial prosthesis constructed to mask facial or jaw deformities/defects as the result of surgery, congenital or developmental issues.
- 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 or occlusion.
- Charges for surgical services in connection with orthodontia, except those listed under covered services (e.g., removal of third molars prior to placing orthodontic appliances, gingivectomies to expose tooth/root surfaces, removal of teeth to manage the crowding of teeth, orthodontic distraction appliances, and etc.).
- 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).

Benefit Exclusions *(cont'd.)*

- Bone or soft tissue grafts to fill-in a tooth socket after an extraction or as a result of iatrogenic issues or complications associated with an oral surgical procedure.
- 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 to include "morning aligners."
- 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.
- Any dental service for which the person is not legally obligated to pay as specified in the Provider Contract or for services for which no charge is made to the person.
- 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.).
- 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 initially performed.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

References

Blue Shield Smile Basic Dental Plan

Blue Shield of California Utilization Management Matrix