

Dental Benefits

Dental Benefits are provided through Delta Dental of California.

Upon enrollment you will receive a dental provider directory that lists Delta Dental dentists participating in the Healthy Kids program. This directly will assist you in choosing a dentist that is accessible and who speaks your language. We encourage you not to wait until you have a problem to see your dentist, but to see him/her on a regular basis. When you choose a network dentist from the list of participating dentists, you can receive any necessary covered preventative or corrective dental care *services* at that location.

If you have a question or grievance regarding eligibility, covered *services*, the denial of dental *services* or claims, policies, procedures and operations of the dental program, or the quality of dental *services* performed by a network dentist, you may contact Delta Dental's Healthy Kids Member Services toll free number at **(866) 212-2743**, Monday through Friday, 7:15am to 5:00pm. For emergency situations they are available 24 hours a day, seven days a week. Please refer to Group Number SF60.

A. Choice of Physician and Provider

The Delta Dental provider directory provides you with the names of network dentists in the City and County of San Francisco. The directory also gives you information about office facilities including wheelchair accessibility and languages spoken within each office. You can select any dentist listed in the directory. If you have special health care needs, contact Delta's Member Services department for assistance in finding a dentist who can best meet your needs.

B. Scheduling Appointments

After you have selected a network dentist, call the dentist to schedule an appointment. Tell the dentist you are covered by Delta under the Healthy Kids program and ask the dentist to confirm that he or she is a network dentist. During your first appointment, be sure to give your dentist the following information:

1. Your group number (can be found on your *member* identification card: SF60);
2. The name of your program: Healthy Kids program;
3. The *member's* client identification number; and,
4. Any other dental coverage you have.

C. Referrals to Specialists

Your network dentist may refer you to another dentist for a consultation or specialized treatment. If this is done, be sure that the dentist you are referred to is a network dentist. You can do this simply by asking the specialist when you make your appointment. *Specialists* are also listed in the Delta Dental - Healthy Kids Provider Directory. Remember if the dentist is not a network dentist, you will be responsible for the cost of treatment.

D. Changing Your Dentist

You can choose any network dentist at any time. If you wish to change dentists, simply review the directory of network dentists in your area and call to schedule an appointment. If your dentist stops participating in Delta's Healthy Kids provider network, you will be notified 90 days in advance. Delta's Healthy Kids Member Services department is available to assist you in choosing a new dentist.

E. Second Opinions

Second Opinions are performed by a regional consultant, who conducts clinical examinations, prepares objective reports of dental conditions and evaluates treatment that is proposed or has been provided.

A *second opinion* may be required prior to treatment when necessary to make a *benefit* determination. *Authorizations* for *second opinions* after treatment can be made if a *member* has a grievance regarding the quality of care provided. You and the treating

dentist will be notified when a *second opinion* is necessary and appropriate. When a *second opinion* is *authorized* through a regional consultant, all charges will be paid by Delta Dental. Enrollees may otherwise obtain a *second opinion* about treatment from a network dentist they choose, and claims for the examination or consultation may be submitted for payment. Such claims will be paid in accordance with the *benefits* of the program.

This is a summary of the Delta Dental policy on *second opinions*. A copy of the formal policy is available upon request by contacting the Delta Dental Healthy Kids Member Services department at toll free **(866) 212-2743** and refer to Group Number SF60.

F. Emergency and Urgent Dental Care Services

An emergency or urgently needed dental *service* is a dental *service* required for, or under the circumstances, reasonably believed to be required for, treatment of severe pain, swelling or bleeding or the immediate diagnosis and treatment of unforeseen dental conditions which, if not immediately diagnosed and treated, would lead to serious deterioration in health, disability or death.

G. How to Get Emergency or Urgent Dental Care Services

Prior approval from Delta Dental is not required for emergency or urgently required dental Services. You can receive emergency dental *services* 24 hours a day, seven days a week. In the case of an emergency, you should call your regular network dentists or any other network dentist. If you need additional assistance call Delta's Healthy Kids Member Services department at toll free **(866) 212-2743** and refer to Group Number SF60.

If you are outside California, you still have 24 hours, seven days a week emergency coverage. You can get emergency dental *services* from any licensed dentist without prior approval from Delta. All emergency *services* by out-of-state dentists are paid at the allowable rate by Delta for emergency treatment. The treating dentist should call toll free at **(866) 212-2743** for payment and *benefits* information.

H. Follow-Up Care

Instructions for follow-up care after an emergency or urgently needed *service* will be provided by the treating dentist. Follow the directions provided by the treating dentist on follow-up care or call your network dentist for more information.

I. Dental Services That Are Not Covered

If you receive non-emergency *services* from a dentist who is not a network dentist, you are responsible for payment to the dentist.

J. Payment Responsibilities

Delta pays network dentists directly. Delta Dental's agreement with your dentist makes sure that you will not be responsible to the dentist for any money for a *covered service* other than *other charges (co-payments)*. There are no other charges (co-payments) required for preventative *services*.

K. Your Dental Benefits

Delta Dental covers several categories of *benefits* when those *services* are provided by a network dentist, and when they are necessary and customary under the generally accepted standards of dental practice

1. Diagnostic and Preventative Benefits

Diagnostic - initial and periodic oral examinations, x-rays, palliative emergency office visits, and consultation by a specialist.

Preventative - prophylaxis (cleaning), fluoride treatment, dental sealants, preventative dental education and oral hygiene instruction.

Space Maintainers - covered *benefits* include space maintainers, include removable acrylic and fixed band type.

2. Restorative, Oral Surgery, Endodontic and Periodontic Benefits

Restorative - amalgam, composite resin, acrylic, synthetic or plastic restorations (fillings) for treatment of cavities (decay). Related pin and pin build up in conjunction with a restoration.

Sedative bases and sedative fillings are also included as *benefits*.

Oral Surgery - extractions, surgical removal of impacted teeth, biopsy of oral tissues, and other surgical procedures, such as: alveolectomies, excision of cysts and neoplasms, treatment of palatal and mandibular torus, frenectomy, incision and drainage of abscesses, root recovery (separate procedure) and post-operative *services* including exams, suture removal and treatment of complications.

Endodontic - direct pulp capping, pulpotomy and vital pulpotomy, apexification filling with calcium hydroxide, root amputation, root canal therapy, apicoectomy and vitality tests.

Periodontic - emergency treatment, including treatment for periodontitis; periodontal scaling and root planning, and sub-gingival curettage; gingivectomy and osseous or muco-gingival surgery.

3. Crown and Fixed Bridge Benefits

Crowns - including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel as necessary to treat cavities that cannot be directly restored with amalgam, composite resin, acrylic, synthetic, or plastic fillings. Related dowel pins and pin build-up are also included.

Fixed Bridges - which are cast, porcelain baked with metal, or plastic processed to gold. Benefit Includes:

- (1) Recementation of crowns, bridges, inlays, and onlays as a covered benefit,
- (2) Cast post and core, including cast retention under crown, and
- (3) repair or replacement of crowns, abutments or pontics as a covered benefit.

4. Removable Prosthetic Benefits

Dentures - *Covered benefits* include construction or repair of partial dentures and complete dentures when provided to replace missing, natural teeth. *Benefits* also include office or laboratory relines or rebases; denture repair; denture adjustments; tissue conditioning; stayplates; and denture duplication. Implants are considered an optional benefit.

5. Orthodontic Benefits

Orthodontic treatment is not a benefit of this dental plan. However, orthodontic treatment will be provided by the California Children Services (CCS) Program if the *member* meets the eligibility requirement for *medically necessary* orthodontia coverage under the CCS Program.

6. Other Dental Benefits

Other dental *benefits* include (1) Local anesthetics, (2) Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure, (3) Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure, and (4) Coordination of *benefits* with the Health Plan in the event hospitalization or *outpatient* surgery setting is medically appropriate for dental *services*.

L. Dental Benefit Exclusions and Limitations

The covered dental benefit for each member will be limited to fifteen hundred dollars (\$1,500) per benefit year. This means that the SFHP Healthy Kids Program will pay for covered dental services up to \$1,500 per benefit year*. Once the limit is reached, you will have to pay for all dental services. The requirements for co-pays stay the same.

*Benefit Year means the twelve (12) month period commencing July 1 of each year at 12:01 am.

If you have any questions, please call the San Francisco Health Plan Member Services Department at (415) 547-7800 or (800) 288-5555. The TDD line for the hearing or speech impaired is (415) 547-7830.

Dental X-rays are limited as follows:

- **Bitewing x-rays** are limited to one set of four films in any consecutive SIX month period. However, isolated bitewing or periapical films are allowed on an emergency or episodic basis.
- **Full mouth x-rays** in conjunction with a periodic exam are limited to once every 24 months.
- **Panoramic film x-rays** are limited to once every 24 consecutive months.
- Prophylaxis Services (cleanings) are limited to two in a 12-month period.
- Dental sealant treatments are limited to permanent first and second molars only.

Restorations are limited as follows:

- If the tooth can be adequately restored with amalgam, composite resin, acrylic, synthetic or plastic restorations materials, any other restoration such as a crown or jacket is considered optional.
- Composite resin or acrylic restorations in posterior teeth are considered optional.
- Only micro filled resin restorations that are non-cosmetic are allowed.
- Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

Root canal therapy, including culture of canal is limited as follows:

- **Retreatment of root canals** is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms.
- **Removal or retreatment of silver points**, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

Periodontal scaling and root planing, and subgingival curettage are limited to five quadrant treatments in any 12 consecutive months.

Crowns are limited as follows:

- **Replacement of each unit is limited** to once every 36 consecutive months, except when the crown is no longer functional.
- **Only acrylic crowns and stainless steel crowns are a benefit** for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.
- **Crowns will be covered only if** there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

- **Veneers** posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

Fixed bridges are limited as follows:

- **Fixed bridges will be used only when** a partial cannot satisfactorily restore the case, it is considered optional treatment.
- **A fixed bridge is covered when** it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a *member* under the age of 16, the *applicant* must pay the difference in cost between the fixed bridge and a space maintainer.
- **Fixed bridges used to replace missing posterior teeth** are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- **Fixed bridges** are optional when provided in connection with a partial denture on the same arch.
- **Replacement of an existing fixed bridge** is covered only when it cannot be made satisfactory by repair.

Five units of crown or bridgework per arch are allowed. The sixth unit is considered full mouth reconstruction and is an optional treatment.

Dentures (full maxillary, full mandibular, partial upper, partial lower), teeth, clasps, denture repair, adjustment and duplication, tissue conditioning (two per denture) and stress breakers are limited as follows:

- **Partial dentures** will not be replaced within 36 consecutive months, unless:
- It is necessary due to **natural tooth loss** where the addition or replacement of the teeth to the existing partial is not feasible, or
- **The denture is unsatisfactory** and cannot be made satisfactory.
- **The covered dental benefit for partial dentures** will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborated or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the *applicant* will be responsible for all additional charges.
- **A removable partial denture** is considered an adequate restoration of a case when teeth are missing on both sides of the same dental arch. Other treatments of such cases are considered optional.
- **Full upper and/or lower dentures** are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by relining or repair.
- **The covered dental benefit for complete denture(s)** will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the *applicant* will be responsible for all additional charges.
- **Office of laboratory** relines or rebases are limited to one per arch in any 12 consecutive months.
- **Stayplates** are a benefit only when used as anterior space maintainers for children and to replace extracted anterior teeth for adults during a healing period.

M. Dental Benefit Grievances

If you have a concern or a grievance regarding any dental *service* you have received you should contact a Member Services representative at Delta Dental at (877) 580-1042, Monday through Friday from 7:15am through 5:00pm **To submit a**

grievance electronically, please visit Delta Dental's web-site at <http://www.deltadentalca.org>.

1. At the Main Menu please select "Contact Us",
2. Please select "State, County and Local Dental_Programs"
3. Under "To file a grievance", please select "Patient grievance form".

Members who have a grievance involving the *services* received from Delta Dental may also contact San Francisco Health Plan at **(415) 547-7800** (local) or **(800) 288-555**.

If you have questions about the *services* you receive from a network dentist, first discuss the matter with your dentist. If you continue to have concerns, call Delta Dental's Member Services department. If appropriate, an arrangement can be made for you to be examined by another dentist in your area. If the dentist recommends that the work be replaced or corrected, Delta Dental will intervene with the original dentist to either have the *service* replaced or corrected at no additional cost to you. In the latter case, you are free to choose another network dentist to receive your full benefit.

The representative will try to resolve the problem immediately; however, sometimes more than one day is needed to investigate and gather information. In this case, the representative will contact you within 30 days to tell you of the results of the review. You may contact a Delta Dental Member Services representative or your network dentist's office to file a grievance. Grievance forms are available from Delta Dental Member Services, on-line at the Delta Dental web site or from your network dentist's office. A Delta Dental Member Services representative will fully explain the grievance instructions and procedures. A network dentist staff member can also help you fill out the form and file it, but we strongly encourage you to contact a Delta Dental Member Services representative to ensure that the form is accurately completed.

If you file a grievance in writing, include the group name and number SF60, the *member's* name and *member* identification number and a telephone number on all correspondence. You should also include a copy of the treatment form (available from your dentist) and any other relevant information. Delta Dental's address and telephone number are as follows:

Delta Dental-Healthy Kids

P.O. Box 537010
Sacramento, Ca. 95853-7010
Toll Free **(866) 212-2743**

Delta Dental will acknowledge receipt of the grievance form within five (5) business days of its receipt. Resolution will occur within 30 days of filing. To file a grievance, take one of these actions:

- Complete a grievance form and send it to Delta Dental's Member Services,
- Call a Delta Dental Healthy Kids Member Services representative at toll free **(866) 212-2743** and state your grievance,
- Submit a grievance electronically on Delta Dental's web-site at <http://www.deltadentalca.org>. or,
- Visit your network dentist's office and request a grievance form in person. Dental office staff may assist you in filling out the form.

You will receive a letter from Delta Dental concerning the disposition of the grievance.

If your grievance involves a serious and imminent threat to the patient's health, please call Delta Dental's Member Services department and state you want to file an urgent grievance. Your urgent grievance will be assigned highest priority and resolved within three (3) business days from receipt.

If you have a grievance involving dental *services*, you should first contact Delta Dental at toll free **(866) 212-2743** and use Delta Dental's grievance process. However, if within 30 days after filing your grievance you need help, a grievance has not satisfactorily resolved by Delta Dental, or you are not satisfied with the result of Delta Dental's grievance process, you have the option to contact the Department of Managed Health Care as described in Section 15 of this Combined Evidence of Coverage/Disclosure Form or you may use the grievance process administered by San Francisco Health Plan.