



**Dental Benefits Summary**  
**Delta Dental PPO plus Premier**

**MOUNT LAUREL TOWNSHIP**  
**BOARD OF EDUCATION**

**Group # 7654**

## **Topics Covered in This Booklet**

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*Please note: The definitions for the words that appear in italics in the following pages can be found in the Glossary. In the event there appears to be any difference between the benefits described in this booklet and those provided in the group contract, the group contract shall prevail.*

## **About This Brochure**

This brochure contains a general description of your dental care program for your use as a convenient reference. All benefits are governed by the provisions of your group's contract with Delta Dental of New Jersey, Inc. This is not a summary plan description designed to meet the requirements of ERISA.

## **About Delta Dental**

Delta Dental of New Jersey, Inc. covers more than one million people in commercial, school board, and government programs. It is our mission to promote oral health to the greatest number of people by providing accessible dental benefits programs of the highest quality, service, and value.

Since 1969, Delta Dental, a not-for-profit dental service corporation, has led the industry in offering innovative programs designed to control costs while ensuring quality of benefits.

Delta Dental is a member of the Delta Dental Plans Association, a national system of not-for-profit dental service corporations covering 54 million people across the country. The national Delta Dental system is the oldest and largest dental benefits system in the country.

In Connecticut, Delta Dental Insurance Company writes dental coverage on an insured basis and Delta Dental of New Jersey administers self-funded dental benefit programs.

## **How to Use Your Program**

Before visiting the *dentist*, check to see whether your *dentist* participates with Delta Dental in your program (e.g., *Delta Dental PPO plus Premier*).

At the time of your first appointment, tell your *dentist* that you are covered under this Delta Dental program. Give him or her your group's name and group number, as well as your Subscriber's ID number. Your dependents, if covered, also must give your number.

After your *dentist* performs an examination, he or she may submit a *Pre-Treatment Estimate* of benefits to Delta Dental to determine how much of the charge for any future work will be your responsibility.

Before treatment is started, be sure you discuss with your *dentist* the total amount of his or her fee. Although *Pre-Treatment Estimates* are not required, Delta Dental strongly recommends you ask your *dentist* to submit a *Pre-Treatment Estimate* for treatment costing \$300 or more. This is especially important when using a *non-participating dentist* because the *Pre-Treatment Estimate* lets you know in advance how much of the costs are your responsibility. Please keep in mind that *Pre-Treatment Estimates* are only estimates and not a guarantee of payment.

## **Locating a *Dentist***

Delta Dental offers two easy ways to locate a *participating dentist* **24 hours a day, 7 days a week**. Subscribers can either:

- Call 1-800-DELTA-OK (1-800-335-8265)
- Search the Internet at [www.deltadentalnj.com](http://www.deltadentalnj.com)

By calling the toll-free number, you can obtain a customized list of *participating dentists* within the geographic area of your request. Delta Dental mails the list to your home.

By searching on the Internet, you can obtain a list of *participating dentists* in a specific town. The list can be downloaded immediately, and you can search for as many towns as needed.

Using either method, you can request a list of Delta Dental *participating dentists* within a designated area. You can specify listings of *general dentists* only or specialists only. *Participating dentist* information can be obtained for *dentists* nationwide.

## **Why Select a *Participating Dentist*?**

All Delta Dental *participating dentists* have agreed, in writing, to abide by our claims processing procedures. Through their commitment and support, we, in turn, can provide you with a program that's tailored to meet your dental health wants and needs.

- *Participating dentists* have agreed to accept the least of their actual charge, their prefiled fee, or Delta Dental's maximum allowable fee for the program as payment in full and to not charge patients for amounts in excess of those indicated in the "patient payment" portion of the *Explanation of Benefits*.
- *Participating dentists* will usually maintain a supply of *claim forms* (also referred to as Attending Dentist's Statements) in their office. You may be asked to complete a portion of the form when you visit.
- *Participating dentists* will complete the rest of the form, including a description of the services that were performed or will be performed in the case of a *Pre-Treatment Estimate*, and require that you sign the *claim form* in the appropriate place. For *dentists* who submit claims electronically to Delta Dental, you will need to authorize your *dentist* to maintain your signature on file.
- *Participating dentists* will mail, fax, or electronically submit the *claim form*, together with the appropriate diagnostic materials, directly to our offices for processing.
- *Participating dentists* agree to abide by Delta Dental processing policies. For example, *participating dentists* agree not to bill separate charges for infection control measures. *Non-participating dentists* are not bound by such policies.

- *Participating dentists* will, in the case of dental services which have been completed, receive payment directly from Delta Dental for that portion of the *treatment plan* which is covered by your dental program. You will receive an *Explanation of Benefits* with a detailed description of covered benefits and the amount of your obligation.
- If you visit a *non-participating dentist*, you will be responsible for payment. Delta Dental will reimburse you for the portion of your services covered by your program.

We advise that you check with your *dentist* to confirm whether he or she participates in the Delta Dental program under which you are covered. While a *dentist* may participate with Delta Dental, he or she may not participate in all of our programs.

### Where Do I Call/E-mail?

<u>Question</u>	<u>Phone Number</u>	<u>E-mail Address</u>
Customer Service	800-452-9310	service@deltadentalnj.com
Obtain <i>claim forms</i>	800-452-9310	service@deltadentalnj.com
<i>Explanation of Benefits</i>	800-452-9310	service@deltadentalnj.com
Status of a claim	800-452-9310	service@deltadentalnj.com
Eligibility information	800-452-9310	service@deltadentalnj.com
Benefits information	800-452-9310	service@deltadentalnj.com
Completing the <i>claim form</i>	800-452-9310	service@deltadentalnj.com
<i>COBRA</i> matters	973-285-4145	administration@deltadentalnj.com
<i>Participating dentist</i> list	800-DELTA-OK 800-335-8265	<a href="http://www.deltadentalnj.com">www.deltadentalnj.com</a>

Please note that all calls to our toll-free number first go through our *Interactive Voice Response (IVR)* system. Information available on the *IVR* includes eligibility, benefits, remaining maximum, *deductible*, claim payments, and ordering *claim forms*. Your question may be answered quicker by the *IVR*, where there is never a wait. You can also use this system to speak with a Customer Service agent. Note: A touch-tone phone is required.

We offer the following services for our non-English speaking and hearing-impaired subscribers:

Language Line Helper - a non-English speaking subscriber can also use our toll-free number. When the call is received, a translator will be obtained for the language the caller is fluent in and a three-way conversation will be held among the caller, translator, and a Delta Dental customer service agent.

TDD Line - a hearing-impaired subscriber can call 1-800-246-1020 Monday through Friday, 8:00 a.m. – 7:00 p.m. and be connected with a TDD machine to also access our Customer Service agents.

## **If You Have Coverage Through Another Plan--*Coordination of Benefits***

Generally, if you are covered by more than one group dental plan and in some cases a group medical plan, your expenses will be shared between the plans, up to the full amount of the allowable charges. This includes dual Delta Dental coverage, as well as coverage by Delta Dental and another group plan.

Make sure you inform your *dentist* that you are covered by more than one plan. If you are covered by more than one Delta Dental of New Jersey plan, you just need to submit the claim once, and we will coordinate your benefits. If you are covered by Delta Dental and another group plan, you need to submit the claim to the primary group plan first. After the primary group plan has issued a statement of benefits, you need to send that statement of benefits to the second group plan along with a *claim form*.

Some groups coordinate benefits according to the *birthday rule* and some groups coordinate benefits according to the *gender rule*. Please see the Eligibility section to determine which rule your group follows for coordination of benefits.

By coordinating benefits, we avoid duplication of payment for the same services, managing your benefits dollars for future procedures and ensuring your group that we are effectively administering your benefits.

## **Continuation of Coverage (*COBRA*)**

Under the Consolidated Omnibus Budget Reconciliation Act (*COBRA*), you and/or your eligible dependents may have the right to elect to continue certain group health coverage which would otherwise end as a result of any of the following events:

- termination of employment for reasons other than gross misconduct;
- a reduction of your hours so that you or your dependents no longer meet the eligibility requirements for coverage;
- your death;
- your legal separation or divorce;
- your child no longer qualifies as a dependent.
- you or your spouse becomes entitled to Medicare.
- your becoming eligible under the Trade Adjustment Assistance Reform Act of 2002

If coverage is to continue, you and/or your eligible dependents will be responsible for paying the contributions and fees required for that coverage. Please see your plan administrator for additional information about *COBRA*.

**DELTA DENTAL OF NEW JERSEY (Delta Dental)  
BENEFIT DETERMINATION AND APPEAL PROCESS SUMMARY**

**Introduction:** The United States Department of Labor has adopted regulations governing claim adjudication and appeals for group health plans governed by ERISA. The new claims and appeals procedures apply to all ERISA plans, whether insured ("risk") or self-funded ("ASO" or "ASC").

Below is the Delta Dental of New Jersey (Delta Dental) Benefit Determination and Appeal Process. The procedures apply to ERISA plans. Delta Dental is currently voluntarily applying these procedures to non-ERISA plans whenever feasible.

**Applicability:** This process applies to all ERISA plans for which Delta Dental provides coverage or administration. Delta Dental has also elected to apply this process to non-ERISA plans for which Delta Dental provides coverage on a risk basis.

**Predetermination of Benefits:** This group dental plan **does not require** prior approval of dental services. Nonetheless, a Covered Individual and his/her treating Dentist may request a predetermination of benefits to obtain advance information on the plan's possible coverage of services before they are rendered. Payment, however, is limited to the benefits that are covered under this plan as of the date service is rendered and is subject to any applicable deductible, waiting periods, annual and lifetime coverage limits as well as this plan's payment policies.

**Notice of Adverse Benefit Determination:** If a claim is denied in whole or in part, Delta Dental shall notify the Subscriber and the treating Dentist of the denial in writing, by issuing an Explanation of Benefits (sometimes referred to as an Adverse Benefit Determination), within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 15 days, for processing. If an extension is necessary, Delta Dental shall notify the Subscriber and the Dentist of the extension and the reason it is necessary within the original 30-day period. If an extension is taken because either the Subscriber or the Dentist did not submit information necessary to decide the claim, the notice of extension shall specifically describe the required information and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

**Explanation of Benefits Form:** This form includes the following information:

- The processing policy or policies (numerical code(s)) stating the specific reason(s) why the claim was denied, including a reference to specific plan provisions on which the denial is based; whether a specific rule, guideline or protocol was relied upon in making the Adverse Benefit Determination and if so, that a copy will be provided free of charge upon request; and a description of any additional information needed in order to perfect the claim as well as the reason why such information is necessary
- Reference in the processing policy or policies to the relevant scientific or clinical judgment, if the Adverse Benefit Determination is related to dental necessity, experimental treatment or other similar exclusion or limitation
- A description of Delta Dental's claim informal appeal and formal appeal processes and the time limits applicable to the processes, including a statement of the Subscriber's right to bring a civil action under ERISA (if applicable)

### **Request for Informal Review**

If the Subscriber or the billing Dentist disagrees with Delta Dental's Adverse Benefit Determination, either may within sixty (60) days of the mailing date of the Adverse Benefit Determination deliver a request to Delta Dental for informal review of the Adverse Benefit Determination. The procedure is explained on the reverse side of the Explanation of Benefits form. Delta Dental will issue its decision on the Informal Review within 60 days after receipt of the Informal Appeal. Subscribers are not required to request informal review. Any appeal relating to the original decision or the Informal Appeals decision must be made within 240 days following the mailing date of the original Adverse Benefit Decision.

**Request for Appeal of Adverse Benefit Determination:** If the Subscriber disagrees with Delta Dental's adverse Benefit Determination, he/she may appeal this determination to Delta Dental within 240 days following the mailing date of the original Adverse Benefit Determination. The appeal must be in writing and must state why it is believed that Delta Dental's benefit decision was incorrect. The denial notice, as well as any other documents or information bearing on the claim, should accompany the appeal request. Delta Dental's review of the claim upon appeal will take into account all comments, documents, records or other information submitted by the claimant, regardless of whether such information was submitted or considered in the initial benefit determination.

**Delta Dental's Review:** The review shall be conducted by a person who is neither the individual who made the initial claim denial nor the subordinate of such individual. If the review is of an Adverse Benefit Determination based in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the person who made the initial claim denial nor the subordinate of such individual. Delta Dental shall provide upon request of the claimant the name of any dental consultant whose advice was obtained in connection with the claim denial, whether or not that advice was relied upon in making the initial benefit determination.

**Notice of Review Decision:** Delta Dental shall notify the claimant in writing of its decision on the Formal Appeal within 30 days of its receipt of the appeal, unless it determines that special circumstances require an extension of time for processing as detailed below. In such cases, written notice of the extension shall be furnished to the claimant prior to the end of the initial 30-day period. In no event shall such extension exceed a period of 60 days from the end of the initial 30-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which Delta Dental expects to render the determination on the appeal.

If Delta Dental upholds the Adverse Benefit Determination on appeal, the notice to the claimant shall include the following information:

- The processing policy or policies (numerical code(s)) stating the specific reason(s) for the adverse determination, with reference to specific plan provisions upon which the determination is based, whether a specific rule, guideline or protocol relied upon in making the determination, and if so, that a copy will be provided free of charge upon request



- Reference in the processing policy or policies to the relevant scientific or clinical judgment, if the Adverse Benefit Determination is related to dental necessity, experimental treatment or other similar exclusion or limitation
- A statement that reasonable access to and copies of all documents, records and other information relevant to the denied claim are available free of charge upon request
- Advice that options for further recourse or for obtaining information may include contacting the state regulatory agency or local U.S. Department of Labor office, or bringing a civil action under ERISA

\*\*For the full version of the appeals process, please contact Delta Dental.

### **Health Care Fraud**

It is insurance fraud to submit false information to a plan in order to obtain a larger payment than you are entitled to receive. False claims include submitting a claim for a service not actually rendered, misdescribing a service which was rendered, misrepresenting the amount of the fee the *dentist* charged and intended to collect (including failing to disclose that the *dentist* will waive all or part of the patient's copayment), or using an incorrect date for the actual rendering of the dental service.

Insurance fraud hurts everyone because it reduces the funds available to pay **bona fide** claims and can result in the termination of benefit plans due to increased costs. It has severe criminal and civil consequences to those who participate in the preparation or submission of such claims. We urge all plan participants to refrain from submitting or participating in the submission of false claims and to contact us at 973-285-4167 if you suspect that a false claim has been submitted.

## Frequently Asked Questions

- Do I need to have an assigned *dentist*?

No, this plan allows you to be treated by any licensed *dentist* of your choice. Generally, the least out-of-pocket expense can be achieved by using a *dentist* who participates with your specific plan type (e.g.: *Delta Dental PPO plus Premier*).

- Do I need a referral to a specialist?

You are not required to have a referral to a specialist if you or your dependents require specialized care. Generally, you will maximize your benefits by utilizing the services of a specialist who participates with Delta Dental.

- Is it required to have a *Pre-Treatment Estimate* (pre-determination of benefits)?

No, it is not required by Delta Dental that you obtain a *Pre-Treatment Estimate* of benefits prior to treatment. If your *dentist* indicates the need for treatment with dental charges in excess of \$300, it is strongly recommended that you request an estimate of dental benefits before receiving the treatment. Both you and your *dentist* will receive a voucher from Delta Dental showing the estimated payable benefit. It will also indicate your estimated patient responsibility including *deductible* if applicable. Your *dentist* needs to complete this voucher and submit it for payment when work has been completed. *Pre-Treatment Estimates* are only estimates and not a guarantee of payment. Payments of the approved services are subject to eligibility and to contract limitations (e.g., annual maximums) at the time services are rendered.

- Do I need an ID card as proof of coverage when I visit a *dentist*?

If your employer has issued an identification card, you should show it to your *dentist*. However, it is not required that a *dentist* see an ID card before rendering treatment. An ID card does not verify active coverage. You or your *dentist* may obtain your group number, current eligibility and benefit information by contacting Delta Dental at (800) 452-9310 24 hours a day, 7 days a week or by accessing Delta Dental's on-line Benefit's Connection tool at [www.deltadentalnj.com](http://www.deltadentalnj.com).

- What if I have questions about my benefits?

You can call our Customer Service Department at (800) 452-9310 and speak to a representative between 8:00 a.m. and 6:30 p.m. EST Monday-Thursday and between 8:00 a.m. and 5:00 p.m. EST Friday. Also, our *interactive voice response* system can provide benefit, eligibility, remaining maximum and *deductible* information, and history of your recent claims 24 hours a day, 7 days a week along with Delta Dental's on-line Benefit Connection tool.

- How do I file a claim for dental charges?

There are several easy ways to submit a claim. Your *dentist* can complete a Delta Dental *claim form* or an ADA (American Dental Association) approved form and mail it to: Delta Dental of New Jersey, P.O. Box 222, Parsippany, NJ 07054-0222. The *claim form* may also be faxed to 1-800-324-7939. If your *dentist* files claims electronically through his or her computer, no *claim form* is required. This method also speeds processing time.

Also, you may download a claim form from our web site and submit the claim as well.

Each individual patient must have his or her own claim filed separately from another family member's claim. Also, each different *dentist* visited must submit a separate claim. However, an individual *dentist* may submit a claim for payment and a *Pre-Treatment Estimate* on the same *claim form*.

- What must the claim form contain?

The claim must contain the treating dentist's signature and either the covered person's signature or a representation from the treating dentist that the covered person has signed a written authorization for the dentist to submit the claim. The claim must also name the patient, the specified date of service and fee charged, and request approval for payment of a specific treatment, service or product.

- When will Delta Dental communicate its benefit determination?

Delta Dental will notify you of its benefit determination for urgent care claims as soon as possible but not later than 72 hours after receipt of the claim, providing sufficient information was received. If the claim is not complete, then Delta Dental will notify you or your representative within 48 hours after receipt of the claim.

Delta Dental will notify you of its benefit determination for post-service claims within a reasonable period of time, but not later than 30 days after receipt of the claim. If Delta Dental needs to extend their decision another 15 days, they will notify you of the reason for the extension and estimated determination date prior the initial 30-day period.

- What will Delta Dental do if there is an adverse benefit determination?

If the benefit determination is adverse, Delta Dental will notify you in writing. The notice will specify the reason(s), refer to the specific plan provision, guideline or protocol upon which the determination was based, describe any additional material or information needed for you to complete the claim and explain why such documentation is necessary, and describe the initial appeal process and time limits. In addition, if the adverse determination was based on medical necessity or exclusion for experimental treatment, the notification will either provide an explanation or offer to provide one free of charge upon request.

- Is there a time limit for submitting dental claims?

Yes, in most cases, you have one full year from the date of service to submit your dental claims. If there is coordination of benefits involved and Delta Dental is not the primary carrier, you have one year from the date on which the primary carrier(s) issues a statement of benefits. If the claim is submitted after these time frames, then the services are not covered.

- What can I do if I am dissatisfied with the initial adverse benefit determination?

You can file a request for informal review within 60 days of the adverse determination. You would send it to:

Delta Dental of New Jersey, Inc.  
Attn: Appeals Department  
P.O. Box 222  
Parsippany, NJ 07054

Your request must include the claim number, name and address of the employee, name of the employer, date of service and description of service, your signature and date of signature, date you received Delta Dental's adverse determination, reason(s) why you think the determination was incorrect and any relevant documents and information.

The person making the decision at Delta Dental will be a person who did not make the initial determination and who is not the subordinate of the initial reviewer. The decision-maker for a determination based in whole or in part on medical judgment will consult with a health care professional who has training and experience involved in medical judgment and who was not consulted in the earlier determination(s).

Delta Dental will notify you in writing of its determination within 72 hours for urgent care claims and within 30 days for pre-service claims. If the benefit determination is adverse, the notice will specify the reason(s), refer to the specific plan provision, guide or protocol upon which the determination was based, inform you of your right to receive free of charge, upon request, all relevant documentation, and describe any voluntary, external appeal procedures as well as your right to bring civil (court) action. In addition, if the adverse determination was based on medical necessity or exclusion for experimental treatment, the notification will either provide an explanation or offer to provide one free of charge upon request.

- What can I do if I am dissatisfied with the informal appeal decision?

You or your dentist must request a formal review in writing within 240 days of receipt of the original adverse benefit determination (whether or not you requested an informal review) and send it to:

Delta Dental of New Jersey, Inc.  
Attn: Correspondence Department  
P.O. Box 601  
Parsippany, NJ 07054

The request for a formal review must include the dentist's name, office name, address and license number, the employee's name, subscriber's ID number and date of birth, the patient's name, date of birth, the claim number, the reason(s) why Delta Dental should change its initial decision and the specific decision you are seeking, any relevant information or diagnostic materials, and/or a copy of the claim for the determination you are appealing. You must also sign the request. If the dentist is authorized to act on your behalf he/she must state that and include a DOL authorization form. Delta Dental will notify you in writing of its determination within 72 hours for urgent care claims, and within 30 days for pre- and post-service claims.

- How do eligible children attending college away from home find a *participating dentist*?

A customized list of *participating dentists* for a specific geographic location can be obtained by calling 1-800-DELTA-OK or 1-800-335-8265. This list will be mailed or can be faxed in case of an emergency situation. Also, listings of *participating dentists* throughout the country are available on our web site at [www.deltadentalnj.com](http://www.deltadentalnj.com).

- What form of full-time student documentation will be necessary to file a claim for my college age dependent?

Students may need to provide Delta Dental with verification of full-time student status with the first claim of every new school year if required under your employer's benefit contract. Examples of student documentation are: a copy of a paid tuition statement, a registrar's certificate or grades showing at least 12 credits, or a current validated student ID card. All documents should reflect the school year, which corresponds with dates of treatment provided by your *dentist*. An on-line form is available for use in submitting student documentation via Delta Dental's web site [www.deltadentalnj.com](http://www.deltadentalnj.com).

- How is my plan maximum calculated?

Your *maximum benefits* payable are either based on a *calendar year* or a coverage period (determined by your employer). All procedures that are paid by Delta Dental will be applied to your plan maximum. If your contract provides benefits for orthodontia or other specific benefits such as TMJ coverage, they may have their own separate annual or lifetime limits. In addition, you may have an individual annual maximum or a combined family maximum for everyone under your coverage.

Your plan also includes the *Carryover Max* feature, which enables you to accumulate or “carry over” unused benefits from one coverage period to the next subject to certain conditions and limitations.

Eligibility for *Carryover Max* is based on a calendar year or other coverage period determined by your employer. You must enroll in the plan prior to the effective date of the coverage period from which any benefits will be carried over; otherwise the accumulation of *Carryover Max* benefits will begin at the start of the next coverage period. If you disenroll from your plan, you will lose your current accumulated balance. In addition, the accumulated balance cannot be transferred to another person or plan.

To qualify for the *Carryover Max* benefit, you must receive at least one oral evaluation (dental examination) or prophylaxis (dental cleaning) during the coverage period and submit a claim to Delta Dental for these services on a timely basis. If you do not receive a dental examination or dental cleaning during the coverage period, you will not be eligible to carry over any of your benefit dollars to the following year. Also, any additional accumulated carry over benefit will be lost.

*Carryover Max* allows you to accumulate up to 25 percent of the unused portion of your standard annual benefit maximum to be used in future coverage periods provided that no more than one half (50 percent) of the standard annual benefit maximum was used during the prior coverage period. The additional accumulated benefit amount can never exceed the annual standard benefit maximum. *Carryover Max* benefits do not apply to lifetime maximums that may exist for services such as orthodontics.

If you accumulate additional benefits under *Carryover Max*, your standard annual maximum dollars are used first when determining benefits for dental services completed during the coverage period. Your additional accumulated benefit dollars are used after the standard annual maximum is met.

Claims not received by the last day of the benefit year may affect any additional accumulated benefits credited for the following benefit year. If claims for services covered in the prior benefit year are received after the date the maximum is calculated, the calculation will be adjusted accordingly and you may be required to pay back Delta Dental the excess benefit you received.

- If I am not located in the same state as my employer’s headquarters, where do I call?

No matter where you are located in the country, you can still call the same toll-free number (800-452-9310) to reach our Customer Service Department, Monday to Thursday, 8 a.m. to 6:30 p.m. EST. and Friday 8:00 a.m. to 5:00 p.m. EST. Our *Interactive Voice Response* system is available 24 hours a day, 7 days a week.

- What is an *alternate benefit* provision and how does it work?

The *alternative benefit* provision of your group contract is applied when there are two dentally acceptable ways to treat a dental condition and both procedures are covered. In such cases your benefit is based on the treatment that costs less. This does not mean that your *dentist* made a poor recommendation. In fact, you may use Delta Dental’s payment towards the treatment you choose. Since Delta Dental’s payment is the same no matter which treatment you choose, you may have higher out-of-pocket expenses if you choose the treatment that costs more.

- What is the Oral Health Enhancement Option and how does it work?

Your dental program includes Delta Dental’s Oral Health Enhancement Option (“OHE”), which covers up to four dental cleanings and/or periodontal maintenance procedures in any combination per [calendar year] [twelve-month period] [six-month period] if you have had certain periodontal (gum) services in the past. These services will be covered at the same percentage as specified in the Description of Covered Services section of this booklet. For the additional dental cleaning and/or periodontal maintenance procedures to be covered, you must have had the following dental services in the past:

- Periodontal surgery for any or all partial or complete quadrants;
- Periodontal scaling and planing for any or all partial or complete quadrants;

You will automatically qualify for the additional benefits if Delta Dental processed a claim for periodontal surgery or periodontal scaling and root planing services for you. Otherwise, you can provide proof that you have had these services in the past in one of the three ways:

1. Send a copy of an explanation of benefits from a prior insurance carrier that shows the most recent date(s) of periodontal surgery or periodontal scaling and root planning.
2. Send a copy of a bill from the treating dentist that clearly shows the most recent date(s) of either periodontal surgery or periodontal scaling and root planning.
3. Have your dentist complete the “Oral Health Enhancement Option Qualification Form” and fax, mail, or email the form to Delta Dental of New Jersey.

The Oral Health Option Qualification Form can be found under the “Forms” section of the Delta Dental of New Jersey Web Site ([www.deltadentalnj.com](http://www.deltadentalnj.com)).

Any oral examination associated with the additional cleaning and/or periodontal maintenance procedures is not covered by Delta Dental. You will be financially responsible for the entire cost of any oral examination performed with the additional procedures.

- For more Frequently Asked Question please visit Delta Dental’s web site at [www.deltadentalnj.com](http://www.deltadentalnj.com).



HEADER INFORMATION																																																																																																																																																																					
1. Type of Transaction (check all applicable boxes) <input type="checkbox"/> Statement of Actual Services – OR – <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX																																																																																																																																																																					
2. Predetermination/Preauthorization Number					<b>PRIMARY MEMBER INFORMATION</b>																																																																																																																																																																
<b>PRIMARY PAYER INFORMATION</b>																																																																																																																																																																					
3. Name, Address, City, State, Zip Code Delta Dental of New Jersey, Inc. P.O. Box 222 Parsippany, NJ 07054																																																																																																																																																																					
13. Date of Birth (MM/DD/YY)					14. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			15. Members Identifier (SSN or ID#)																																																																																																																																																													
<b>OTHER COVERAGE</b>																																																																																																																																																																					
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																																																																																																																																																																					
5. Members Name (Last, First, Middle Initial, Suffix)																																																																																																																																																																					
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19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS																																																																																																																																																																					
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip code																																																																																																																																																																					
21. Date of Birth (MM/DD/YY)					22. Gender			23. Patient ID/Account # (Assigned by Dentist)																																																																																																																																																													
RECORD OF SERVICES PROVIDED																																																																																																																																																																					
No.	24. Procedure Date (MM/DD/YY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letters	28. Description of Procedure	29. Diagnosis	30. ICD-9-CM Code	31. Fee																																																																																																																																																													
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34. (Place an 'X' on each missing tooth)																																																																																																																																																																					
<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td colspan="3">1</td><td colspan="3">2</td><td colspan="3">3</td><td colspan="3">4</td><td colspan="3">5</td><td colspan="3">6</td><td colspan="3">7</td><td colspan="3">8</td><td colspan="3">9</td><td colspan="3">10</td><td colspan="3">11</td><td colspan="3">12</td><td colspan="3">13</td><td colspan="3">14</td><td colspan="3">15</td><td colspan="3">16</td><td colspan="3">17</td><td colspan="3">18</td><td colspan="3">19</td><td colspan="3">20</td><td colspan="3">21</td><td colspan="3">22</td><td colspan="3">23</td><td colspan="3">24</td><td colspan="3">25</td><td colspan="3">26</td><td colspan="3">27</td><td colspan="3">28</td><td colspan="3">29</td><td colspan="3">30</td><td colspan="3">31</td><td colspan="3">32</td> </tr> <tr> <td colspan="3">T</td><td colspan="3">S</td><td colspan="3">R</td><td colspan="3">Q</td><td colspan="3">P</td><td colspan="3">O</td><td colspan="3">N</td><td colspan="3">M</td><td colspan="3">L</td><td colspan="3">K</td><td colspan="3">J</td><td colspan="3">I</td><td colspan="3">H</td><td colspan="3">G</td><td colspan="3">F</td><td colspan="3">E</td><td colspan="3">D</td><td colspan="3">C</td><td colspan="3">B</td><td colspan="3">A</td> </tr> </table>										1			2			3			4			5			6			7			8			9			10			11			12			13			14			15			16			17			18			19			20			21			22			23			24			25			26			27			28			29			30			31			32			T			S			R			Q			P			O			N			M			L			K			J			I			H			G			F			E			D			C			B			A		
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35. Remarks																																																																																																																																																																					
<b>AUTHORIZATIONS</b>																																																																																																																																																																					
36. I have been informed of the treatment plan and associated costs. I understand that I am responsible for charges for dental services and materials not paid by my dental benefits plan, or by law, or the treating dentist or dental practice has a contractual agreement with my plan for a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this treatment.																																																																																																																																																																					
X Patient/Guardian signature _____ Date _____																																																																																																																																																																					
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.																																																																																																																																																																					
X Member signature _____ Date _____																																																																																																																																																																					
<b>BILLING DENTIST OR DENTAL ENTITY (leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/member)</b>																																																																																																																																																																					
48. Name, Address, City, State, Zip Code																																																																																																																																																																					
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<b>ANCILLARY CLAIM/TREATMENT INFORMATION</b>																																																																																																																																																																					
38. Place of Treatment (check applicable box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other																																																																																																																																																																					
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)																																																																																																																																																																					
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)																																																																																																																																																																					
41. Date Appliance Placed (MM/DD/YY)					42. Months of Treatment Remaining																																																																																																																																																																
43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)					44. Date Prior Placement (MM/DD/YY)																																																																																																																																																																
45. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																																																																																																																																																																					
46. Date of Accident (MM/DD/YY)					47. Auto Accident State																																																																																																																																																																
<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>																																																																																																																																																																					
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.																																																																																																																																																																					
X Signed (Treating Dentist) _____ Date _____																																																																																																																																																																					
54. Provider ID					55. License Number																																																																																																																																																																
56. Address, City, State, Zip Code																																																																																																																																																																					
57. Phone Number ( ) -					58. Treating Provider Specialty																																																																																																																																																																

### General Instructions:

The form is designed so that the Primary Payer's name and address (Item 3) is visible in a standard #10 window envelope. The upper right blank space is provided for insertion of the third-party payer's claim or control number.

- a) All data elements are required unless noted to the contrary on the face of the form or in the Data Element Specific Instructions that follow.
- b) When a name and address field is required, the full entity or individual name, address and zip code must be entered (i.e., Items 3, 11, 12, 20, and 48).
- c) All dates must include the two-digit year (i.e., Items 6, 13, 21, 24, 36, 37, 41, 44, and 53).
- d) If the number of procedures being reported exceeds the number of lines available on one claim form the remaining procedures must be listed on a separate, fully completed claim form. Both claims forms are submitted to the third-party payer.

### Data Element Specific Instructions

1. EPSDT/ Title XIX – Mark box if patient is covered by state Medicaid's Early and Periodic Screening, Diagnosis and Treatment program for persons under age 21.
2. Enter number provided by the payer when submitting a claim for services that have been predetermined or preauthorized.
- 4-11. Leave blank if no other coverage.
8. The member's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
15. The member's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
16. Member's or employer group's Plan or Policy Number. May also be known as the Certificate Number (not the member's identification number).
- 19-23. Complete only if the patient is **not** the Primary Member (i.e., "Self" not checked in Item 18).
19. Check "FTS" if patient is a dependent and full-time student; "PTS" if a part-time student. Otherwise, leave blank.
23. Enter if dentist's office assigns a unique number to identify the patient that is not the same as the Member Identifier number assigned by the payer (e.g., Chart#).
25. Designate tooth number or letter when procedure code directly involves a tooth. Use area of the oral cavity code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity'.
26. Enter applicable ANSI ASC X12 code list qualifier. Use "**JP**" when designating teeth using the ADA'S Universal/National Tooth Designation System. Use "**JO**" when using the ANSI/ADA/ISO Specification No 3950.
27. Designate tooth number when procedure code reported directly involves a tooth. If a range of teeth is being reported, use a hyphen ('-') to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.
28. Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces:  
**B** = Buccal; **D** = Distal; **F** = Facial; **L** = Lingual; **M** = Mesial; **O** = Occlusal.
29. Use appropriate dental procedure code from current version of *Code on Dental Procedures and Nomenclature*.
31. Dentist's full fee for the dental procedure reported.
32. Used when other fees applicable to dental services provided must be recorded. Such fees include state taxes, where applicable, and other fees imposed by regulatory bodies.
33. Total of all fees listed on the claim form.
34. Report missing teeth on each claim submission.
35. Use "Remarks" space for additional information such as 'reports' for '999' codes or multiple supernumerary teeth.
36. Patient Signature: The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
37. Member Signature: Necessary when the patient/insured and dentist wish to have benefits paid directly to the provider. This is an authorization of payment. It does not create a contractual relationship between the dentist and the payer.
38. ECF is the acronym for **E**xtended **C**are **F**acility (e.g., nursing home).
- 48-52. Leave blank if dentist or dental entity is **not** submitting claim on behalf of the patient or insured/member.
48. The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payment or correspondence that will be remitted to the billing dentist.
49. Identifier assigned to Billing Dentist of Dental Entity other than the SSN or TIN. Necessary when assigned by carrier receiving the claim.
50. Refers to the license number of the billing dentist. This may differ from that of the treating (rendering) dentist that appears in the treating dentist's signature block.
52. The Internal Revenue Service requires that either the Social Security Number (SSN) or Tax Identification Number (TIN) of the billing dentist or dental entity be supplied **only** if the provider accepts payment directly from the third-party payer. When the payment is being accepted directly report the 1) SSN if the billing dentist is unincorporated; 2) Corporation TIN if the billing dentist is incorporated; or 3) Entity TIN when the billing is a group practice or clinic.
53. The treating, or rendering, dentist's signature and date the claim form was signed. Dentist should be aware that they have ethical and legal obligations to refund fees for services that are paid in advance but not completed.
56. Full address, including city, state and zip code, where treatment was performed by treating (rendering) dentist.
58. Enter the code that indicates the type of dental professional rendering the service from the 'Dental Service Providers' section of the *Healthcare Providers Taxonomy* code list. The current list is posted at: <http://www.wpc-edi.com/codes/codes.asp>. The available taxonomy codes, as of the first printing of this claim form, follow in **boldface**.

122300000X Dentist – A dentist is a person of qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of the license.

Many dentists are general practitioners who handle a wide variety of dental needs.

**1223G0001X** General Practice

Other dentists practice in one of nine specialty areas recognized by the American Dental Association:

**1223D0001X** Dental Public Health  
**1223E0200X** Endodontics  
**1223P0106X** Oral & Maxillofacial Pathology  
**1223D0008X** Oral & Maxillofacial Radiology  
**1223S0112X** Oral & Maxillofacial Surgery  
**1223X0400X** Orthodontics

**1223P0221X** Pediatric Dentistry  
(Pedodontics)  
**1223P0300X** Periodontics  
**1223P0700X** Prosthodontics

# Delta Dental Offers Enhanced Explanation of Benefits Statements

Delta Dental's **Explanation of Benefits** statement is presented in a readable, user-friendly format. Developed in consultation with dentists and members, the new form contains more information than before and has been reformatted, making it easier to read.

## What Delta Dental's Improved Explanation of Benefits Statement Offers

- CONTACT INFORMATION**, including a special Customer Service toll-free phone number.
- A PAYMENT SUMMARY BOX**, providing at a glance details about charges, payments, deductibles and patient obligations.

**NEW!** **Dentist Amount Non Billable**, which shows the amount the patient is not billable for.

- PATIENT INFORMATION**, including patient's name, date of birth, relationship to subscriber, group ID and name, and plan type.

**NEW!** **Benefit Period**, which shows the benefit period for the patient.

- NEW!** **CLAIM NUMBER INCREASED**, from 9 digits to 15.

continued on other side



### Explanation of Benefits – Dentist Copy

#### PAYMENT SUMMARY

<b>Total Approved Charges</b>	\$000.00
<b>Delta Dental's Total Payment</b>	\$000.00
<b>Your Other Insurance Paid</b>	\$000.00
<b>Applied to Deductible</b>	\$000.00
<b>Dentist Amount Non Billable <b>NEW!</b></b>	\$000.00
<b>Patient Out of Pocket Payment Obligation</b>	\$000.00

**DO NOT SEND PAYMENT TO DELTA DENTAL**



Delta Dental of New Jersey, Inc.  
P.O. Box 222  
Parsippany, NJ 07054

Claim Inquiries: 800-452-9310 Visit us on the Internet: [www.deltadentalnj.com](http://www.deltadentalnj.com)

JOHN SMITH DMD  
1234 ANY STREET  
SAMPLETOWN, NJ 00000-0000

1

2

3

**PATIENT:** ROBERT JONES  
**PATIENT DATE OF BIRTH:** 00/00/0000  
**RELATIONSHIP:** SUBSCRIBER  
**GROUP ID:** 0000-0000  
**GROUP NAME:** ABC CORPORATION  
**PLAN TYPE:** PREMIER  
**BENEFIT PERIOD: **NEW!**** 00/00/0000 – 00/00/0000

**CLAIM NUMBER:** 0000000000000000  
**DATE OF ISSUE:** 00/00/00  
**CHECK NUMBER:** 0000000000  
**DENTIST ID NUMBER:** 12345NJ  
**DENTIST NAME:** DR. JOHN SMITH  
**PAR STATUS:** PREMIER

4

**NEW!**

5

6

Annual **PLAN MAXIMUM: **NEW!**** \$0000.00 Individual **Used to Date:** \$000.00  
Lifetime **TMJ MAXIMUM:** \$0000.00 Individual **Used to Date:** \$0.00

7

TOOTH NO. OR LETTER	SURFACE	DATE OF SERVICE	SUBMITTED PROCEDURE NO.*	PAID PROCEDURE NO.*	SUBMITTED AMOUNT	APPROVED AMOUNT	AMT USED FOR BENEFIT CALC	DED	% COPAY	DELTA DENTAL PAYMENT	PROCESSING POLICIES
XX	XXXXX	00/00/0000	2391	2140	\$000.00	\$000.00	\$000.00	\$00.00	000	\$000.00	000, 000, 000

**\*PROCEDURE NO. / DESCRIPTION**  
2391 Resin based composite – one surface, posterior  
2140 Amalgam – one surface, posterior

**PROCESSING POLICIES**  
Line One  
Line Two  
Line Three

PLEASE SEE REVERSE SIDE OF THIS FORM FOR INFORMATION RELATED TO OUR NOTICE OF PRIVACY PRACTICES, DEFINITIONS, AND OTHER IMPORTANT INFORMATION.

## IMPORTANT NOTICE TO CLAIMANTS

### 1. Informal Review (Optional to Subscriber)

The covered person (or authorized representative) and/or treating dentist may, within 60 days of the date of mailing of this EOB, request that we informally reconsider this claim decision by following the procedure described in No. 5 below; we will respond within 60 days and notify the subscriber (or authorized representative) and treating dentist of our decision and the reason(s) therefor. If no request is submitted within 60 days, only a formal appeal may be filed. A request for informal review does not constitute an "appeal" for ERISA appeals purposes.

### 2. Formal Appeal

The covered person (or authorized representative) may, within 240 days of the date of mailing of this EOB, formally appeal this claim decision by following the procedure described in No. 5 below; we will issue our decision to the subscriber (or authorized representative) within 30 days of our receipt of the appeal for ERISA claims and within 45 days of our receipt of the appeal for non-ERISA claims.

### 3. Right to Sue

A covered person must timely file a formal appeal (as described in No. 2 above) and receive our decision on the appeal as a precondition to commencing any legal proceeding challenging the claim determination.

### 4. Right to Receive Rules, Guidelines or Detailed Explanations

If the front side of this form indicates that a rule or guideline was relied on, you have a right to receive it free of charge. If the front side indicates that payment was not made for services because they were experimental or not medically necessary, you have a right to receive an explanation of the basis for that decision. To receive either, send your written request to Delta Dental, Attn: Correspondence Department, P.O. Box 222, Parsippany, NJ 07054.

### 5. Procedure for Requesting Informal Reviews and Formal Appeals

Submit the following information and documentation:

- (a) Dentist name, office name, address and license number
- (b) Subscriber name, social security number and date of birth
- (c) Patient name, social security number and date of birth
- (d) Claim number
- (e) Whether this is for an informal review or a formal appeal
- (f) Description of the reasons why Delta Dental should change its initial decision on the claim and the specific decision which you request
- (g) Any supplemental information or diagnostic materials relevant to the claim in question
- (h) In lieu of (a), (b), (c) and (d), attach a copy of the claim and the claim determination you are appealing

A form is available for you to use at [http://www.deltadentalnj.com/HIPAA/law\\_compliance.shtml](http://www.deltadentalnj.com/HIPAA/law_compliance.shtml).

You must sign your request; if you are authorized to act for the covered person, you must state that. You may include information and/or documentation pertinent to the claim even if you had not previously submitted it to us. Informal review requests must be addressed to Delta Dental, Attn: Correspondence Department, P.O. Box 222, Parsippany, NJ 07054. Formal appeals must be addressed to Delta Dental, Attn: Formal Appeals Department, P.O. Box 601, Parsippany, NJ 07054.

### 6. Potential Voluntary Alternative Dispute Options

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency. Those persons covered under a self-funded program may also have a voluntary appeals program available to them; check with your Human Resources Department or Summary Plan Description (SPD) if applicable.

### 7. Notice of Privacy Practices

You may access Delta Dental's Notice of Privacy Practices on our website at [www.deltadentalnj.com](http://www.deltadentalnj.com). You may also obtain a hard copy of this notice by contacting our compliance manager at (866) 861-4716.

### 8. Coordination of Benefits

If you are covered by more than one health benefit plan, you should file all your claims with each plan and provide each plan with information regarding the other plans under which you are covered.

You should always submit your claim first to your primary carrier and, after receiving their determination, submit your claim to your secondary or tertiary carriers (if applicable).

### 9. Terminology and Definitions

**Approved Amount:** The total amount which the dentist is permitted to collect as payment in full for the specified service. It includes the dental benefit plan's payment as well as the patient's deductible and/or copay.

**Amount Used for Benefit Calculation:** The fee amount that the dental benefit plan provides for use in calculating the dental benefit plan payment for the specified service. The dental benefit plan payment may be less than this fee amount due to patient deductible, copay, plan limitations or exclusions.

10. Any procedures which are disallowed resulting in no Delta Dental payment or patient liability are in accordance with the group contract and dentist participation agreement.

11. Payment for all services is determined in accordance with the terms of the group's dental plan and/or with the terms of Delta Dental's dentist participation agreements.

5. **DENTIST INFORMATION**, including the Delta Dental program in which he or she participates for that claim.
6. **NEW! MAXIMUM INFORMATION EXPANDED**, to include all maximums applicable to the plan the patient is covered under instead of showing plan maximum only.
7. **DETAILED EXPLANATIONS AND DESCRIPTIONS OF INFORMATION IN THE COLUMNS**, including descriptions of each procedure number and explanations, if appropriate, of processing policies (up to 3 per line item allowed).

**NEW!** Separate 'Submitted Procedure No.' and 'Paid Procedure No.' added, to better illustrate when an alternative benefit has been applied.

For questions about specific claims, contact the number for Claims Inquiries on your Explanation of Benefits statement, or e-mail Customer Service at [service@deltadentalnj.com](mailto:service@deltadentalnj.com).

## Description of Covered Services

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See following page for program descriptions

Delta Dental PPO plus Premier

### **Preventive & Diagnostic Services (No Deductible)**

100%

- Exams, Cleanings, (each twice per calendar year per person, ages 14 and older are considered adults)
- X-rays-full mouth series or panoramic (either one, once in three years)
- X-rays-bitewing (twice per calendar year)
- X-rays-single films (multiple x-rays on the same date of service will not exceed the benefit of a full-mouth series)
- Fluoride Treatment (once per calendar year, for eligible children to age 19, combinations with cleanings are applied to time limits for both)
- Space Maintainers (once per space for missing posterior primary teeth, for children under age 14)
- Consultations are counted as exams for purposes of frequency limitations

### **Remaining Basic (After Deductible)**

80%

- Fillings - composite and amalgam. Payment is allowed for one restoration per tooth surface in 365 days (composite fillings on back teeth are given the alternate benefit of an amalgam filling)
- Extractions, Oral Surgery (impacted wisdom teeth claims should first go to medical carrier)
- Endodontics (root canals on permanent teeth once per lifetime per tooth)
- Periodontics (have specific frequency limitations, pre-treatment estimate is strongly recommended - e.g. surgery once per 36 months)
- Sealants (1<sup>st</sup> and 2nd permanent, decay-free molars, once in a lifetime per tooth, for children to age 16)

### **Prosthodontics & Crowns (After Deductible)**

80%

- Crowns and crown-related procedures (post and core, core buildup, etc., once every five years, permanent teeth only, for ages 12 and older)
- Bridgework (once every five years, for ages 16 and older) (bridges with four or more missing teeth in that arch may be given an alternate benefit of a partial denture)
- Full & Partial Dentures (either one, once every five years, partial dentures for ages 16 and older) (fixed bridges and removable partial dentures are not benefits in the same arch; benefits will be provided for the removable partial denture only)
- Repair of Dentures (Repair of existing prosthetic appliances)
- Inlays (inlays are only payable when done in conjunction with an onlay; by themselves they are given the alternate benefit of an amalgam filling)

Delta Dental PPO plus Premier

**Calendar Year Standard Maximum (per person)**

\$2,000.00

Carryover Max Feature

- Maximum benefit that can be used during the coverage period to qualify for an additional accumulated benefit
- Maximum amount that can be accumulated and carried into the next coverage period
- Maximum amount that can be accumulated at any point in time

\$1,000.00  
\$500.00  
\$2,000.00

**Calendar Year Deductible**

- Individual
- Family (family deductible is accumulated by individual deductibles)

\$50.00  
\$150.00

**Orthodontia (Employee & Dependents)**

50%

Orthodontic treatment is a benefit limited to once in a lifetime.

- Maximum (Lifetime)
- Deductible (Lifetime)

\$1,250.00  
N/A

**Description of Programs**

**Delta Dental PPO plus Premier** - See Explanation under "Product Descriptions" section at back of booklet.

Under all programs, non-participating dentists may balance bill above the maximum allowable charge.

## **Orthodontic Payment Schedule**

Payment for comprehensive orthodontics will be processed in two (2) equal payments (subject to continuation of treatment and/or eligibility for orthodontic benefits at the time services are rendered).

The first payment will be made upon insertion of appliances. The second and final payment will be made upon the completion of the first twelve (12) months of treatment. These payments will represent Delta Dental's full liability.

When the appliances are inserted prior to the effective date of eligibility, orthodontic benefits will be *pro-rated*.

## **Eligibility Requirements**

Your plan begins when the following requirements have been satisfied:

- All new subscribers and their dependents will be covered from the first of the month following date of hire (minimum of 20 hours per week).

### Eligible Dependents

- Your spouse.
- Domestic partner.
- Dependent children (subject to age limitations).
  - Children include step-children, adopted children, and foster children, provided such children are dependent upon the employee for support and maintenance.
  - Children from birth to age 23.
  - Your legally adopted child (including a child for whom legal adoption proceedings have already been started).
  - Handicapped children - in order for mentally or physically handicapped children to remain covered, you must show proof of the child's incapacity. This proof must be attached to the first claim submitted to Delta Dental.

When does coverage terminate?

Coverage for employees and their eligible dependents shall cease upon the earliest of:

- Termination of employee's employment
- Death of employee
- Termination of group contract

Coverage for dependent spouse shall terminate on divorce from the covered employee unless otherwise stated by divorce decree.

Coverage for a dependent child shall terminate upon the end of the calendar year in which attaining the limiting contract age (see eligibility section).

For coordination of benefits, your group follows the  Birthday  rule.

### **Exclusions and Limitations: Services Not Covered by This Dental Plan**

- To be eligible for coverage, a service must be required for the prevention, diagnosis, or treatment of a dental disease, injury, or condition. Services not dentally necessary are not covered benefits. Your dental plan is designed to assist you in maintaining dental health. The fact that a procedure is prescribed by your dentist does not make it dentally necessary or eligible under this program. We can request proof (such as x-rays, pathology reports, or study models) to determine whether services are necessary. Failure to provide this proof may cause adjustment or denial of any procedure performed.
- Services for injuries or conditions which are compensable under Workers Compensation Employers Liability Laws; services provided to the eligible patient by any Federal or State Government Agency or provided without cost to the eligible patient by any municipality, county, or other political subdivision.
- Services with respect to congenital or developmental malformations (including TMJ and replacing congenitally missing teeth), cosmetic surgery, and dentistry for purely cosmetic reasons (e.g., bleaching, veneers, or crowns to improve appearance).
- Services provided in order to alter occlusion (change the bite); replace tooth structure lost by wear, abrasion, attrition, abfraction, or erosion; splint teeth; or treat or diagnose jaw joint and muscle problems (TMJ).
- Specialized or personalized services (e.g., overdentures and root canals associated with overdentures, gold foils) are excluded and a benefit will be allowed for a conventional procedure (e.g., benefiting a conventional denture towards the cost of an overdenture and the root canals associated with it. The patient is responsible for additional costs.)
- Prescribed drugs, analgesics (pain relievers), fluoride gel rinses, and preparations for home use.
- Procedures to achieve minor tooth movement.
- Experimental procedures, materials, and techniques and procedures not meeting generally accepted standards of care.
- Educational services such as nutritional or tobacco counseling for the control and prevention of oral disease. Oral hygiene instruction or any equipment or supplies required.
- Services rendered by anyone who does not qualify as a fully licensed *dentist*.
- Charges for hospitalization including hospital visits or broken appointments, office visits, and house calls.
- Services performed prior to effective date or after termination of coverage. Benefits are payable based on date of completion of treatment.
- Services performed for diagnosis such as laboratory tests, caries tests, bacterial studies, diagnostic casts, or photographs.
- Temporary procedures and appliances, pulp caps, occlusal adjustments, inhalation of nitrous oxide, analgesia, local anesthetic, and behavior management.



- Procedures or preparations which are part of or included in the final restoration (bases, acid etch, or micro abrasion).
- Transplants, implants, and procedures directly associated with implants including crowns and bridgework and their restoration and their maintenance or repair.
- Periodontal charting, chemical irrigation, delivery of local chemotherapeutic substances, application of desensitizing medicine, synthetic bone grafts, and guided tissue regeneration.
- Post removal (not in conjunction with root canal therapy).
- Completion of claim forms, providing documentation, requests for pre-determination, and services submitted for payment more than twelve (12) months following completion.
- Separate fee for infection control and OSHA compliance.
- Maxillofacial surgery and prosthetic appliances.

This is a general description of your dental plan to be used as a convenient reference, and some exclusions and limitations may not be listed. All benefits are governed by your group contract.

## **Glossary**

### **Term**

### **Definition**

Alternate Benefit	A provision in a dental plan contract that allows the third-party payer to determine the benefit based on an alternative procedure that is generally less expensive than the one provided or proposed. Patient financial liability is dependent upon the treatment chosen.
Amalgam	A silver material used to fill cavities that is placed on the tooth surface that is used for chewing because it is a particularly durable material.
Birthday Rule	Coordination-of-benefits regulation stipulating that the primary payer of benefits for dependent children is determined by the parents' birth dates. Regardless of which parent is older, the dental benefits program of the parent whose birthday falls first in a calendar year is considered primary.
Bitewing	A dental x-ray showing approximately the coronal (crown) halves of the upper and lower jaw.
Calendar Year	For benefit determinations based on a calendar year, this refers to the period of one year beginning with January 1 and ending December 31.
Carryover Max Feature	A benefit option that enables Covered Persons carry over part of the unused standard maximum benefit in one coverage period to increase the amount of benefits available in subsequent coverage periods subject to certain requirements and limitations.
Claim Form	The paper form the dentist must file for reimbursement for services rendered.
COB	Coordination of Benefits. A method of integrating benefits payable under more than one plan.
COBRA	Consolidated Omnibus Budget Reconciliation Act. A law that requires certain employers to offer continued health insurance coverage to eligible employees and/or their dependents who have had their health insurance coverage terminated.
Completion Date	The date a procedure is completed. It is the insertion date for dentures and partial dentures. It is the cementation date (regardless of the type of cement used) for inlays, onlays, crowns, and fixed bridges.

Composite	White resin material used to fill cavities. It is used primarily because the color more closely resembles the natural tooth than does the color of amalgam.
Consultation	A discussion between the patient and the dentist where the dentist offers professional advice for the proposed treatment plan.
Contract Year	A period of one year beginning with the effective date of the group contract.
Covered Family Members	You and your spouse and dependent children who are covered under this program.
Deductible	The amount of dental expense your group requires you to pay before Delta Dental assumes any liability for payment of benefits. Deductible may be an annual or one-time charge, and may vary in amount from program to program.
Delta Dental PPO <sup>SM</sup>	Delta Dental's basic preferred provider option (PPO).
Delta Dental Premier <sup>®</sup>	Delta Dental's traditional fee-for-service dental benefits program.
Dentist	A person licensed to practice dentistry by the appropriate authority in the area where the dental service is given.
Endodontist	A dentist who specializes in diseases of the tooth pulp, performing such services as root canals.
Gender Rule	Coordination-of-benefits regulation stipulating that the primary payer of benefits for dependent children is determined by the gender of the parents. The dental benefits program of the parent of a specified gender is considered primary.
General Dentist	A dentist who provides a full range of dental services for the entire family.
IVR	Interactive Voice Response system. Information can be accessed by touch-tone telephone 24 hours a day on: eligibility, benefits, claim information, and ordering claim forms.
Maximum Benefit	The maximum dollar amount a program will pay toward the cost of dental care incurred by an individual or family in a specified period, usually a calendar year.

Non-Participating Dentist	A state-licensed dentist who does not have a written participation agreement with Delta Dental.
Notification of Delta Dental Benefits	A statement that explains how your claim was processed, payment by Delta Dental, your responsibility, and other pertinent information. Also referred to as an EOB (Explanation of Benefits) or Notification of Payment (NOP).
Oral Health Enhancement Option	A benefit option that provides coverage for additional dental cleanings and periodontal maintenance procedures beyond the normal frequency limits for Covered Persons who received certain periodontal services in the past.
Oral Pathologist	A dentist who is concerned with recognition, diagnosis, and management of the diseases of the mouth, jaws, and surrounding structures.
Oral Surgeon	A dentist who removes teeth, including impacted wisdom teeth, repairs fractures of the jaw and performs surgery on the mouth, jaws, and surrounding structures.
Orthodontist	A dentist who corrects misaligned teeth and jaws, usually by applying braces.
Participating Dentist	A state-licensed dentist who has a written agreement with a Delta Dental Plan to perform services and receive payment under this program.
Participating Specialist	A participating dentist with Delta Dental of New Jersey who holds a specialty permit in endodontics, periodontics, prosthodontics, oral surgery, or orthodontics; limits his/her practice to that specialty; and has registered with Delta Dental as a specialist.
Pediatric Dentist	A dentist who generally limits his/her practice to children and teenagers and the handicapped. Also known as Pedodontist.
Periodontist	A dentist who treats diseases of the gums.
Pre-Treatment Estimate	Pre-authorized estimate of services detailing payment of allowable benefits.
Prevailing Fee	The lowest fee for a single procedure which equals or exceeds the fee for that procedure which Delta Dental has determined will satisfy the majority of dentists in the pertinent geographic location.
Prophylaxis	Prevention of disease by removal of calculus, stains, and other extraneous materials from the teeth. The cleaning of the teeth by a dentist or dental hygienist.

Pro-rated	For subscribers whose orthodontic coverage begins after treatment has begun, payments are divided proportionately over the course of the treatment and Delta Dental's payment is based on the portion during which the subscriber has coverage.
Prosthodontist	A dentist who generally specializes in ways to replace missing natural teeth with bridges and dentures.
Sealant	An adhesive material bonded to the tooth surface to retard decay by shielding the tooth from exposure to the oral environment. This includes preventive resin restorations.
Standard Annual Benefit Maximum	The maximum dollar amount a program will pay toward the cost of dental care incurred by an individual or family in a specified period, usually a calendar year.
Treatment Plan	A written report prepared by a dentist showing the dentist's recommended treatment of any dental disease, defect, or injury.
UCR	The Usual, Customary, and Reasonable fee level as determined by Delta Dental for the pertinent geographic location.

## **Product Descriptions**

### **Delta Dental PPO plus Premier**

Where the eligible patient is treated by a Delta Dental PPO dentist, the fee for the covered service(s) will not exceed the Delta Dental PPO maximum allowable charge(s). Where the eligible patient is treated by a Delta Dental Premier dentist who does not participate in the Delta Dental PPO Program or by a *Participating Specialist*, the dentist has agreed not to charge eligible patients more than the dentist's filed fee or Delta Dental's established UCR, and Delta Dental will pay such dentists based on the least of the actual fee, the filed fee, or Delta Dental's established UCR for the procedure(s). Claims for services provided by dentists who are neither Delta Dental Premier, Delta Dental PPO Program dentists, or *Participating Specialists* are paid based on the lesser of the dentist's actual charge or the prevailing fee.

Your benefit levels may vary based on the program in which your dentist participates as indicated in the schedule of benefits which appears in this booklet.

You are responsible for payment of the difference between Delta Dental's payment and the fee approved by Delta Dental.





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