Dental Benefits Summary
Delta Dental Premier/Advantage Program

RUMSON BOROUGH BOARD OF EDUCATION

Group # 7328

Topics Covered in This Booklet

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 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 28 million people across the country. The national Delta Dental system is the oldest and largest dental benefits system in the country.

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 Premier/ Advantage Program).*

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 Social Security number. Your dependents, if covered, also must give your Social Security 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 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 1-800-452-9310
- Search the Internet at 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 *Notification of Delta Dental 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 a *Notification of Delta Dental 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?

Question	Phone Number	E-mail/Internet Address
Customer Service	800-452-9310	service@deltadentalnj.com
Obtain *claim forms*	800-452-9310	service@deltadentalnj.com
Notification of Delta Dental Benefits statement	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 *claim form*	800-452-9310	service@deltadentalnj.com
COBRA matters	973-285-4145	administration@deltadentalnj.com
Participating dentist list	800-DELTA-OK 800-335-8265	www.deltadentalnj.com

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 representative. 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 representative.

TDD Line - a hearing-impaired subscriber can call 1-800-246-1010 and be connected with a TDD machine to also access our Customer Service representatives.

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.

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.*

Claims and Appeal Procedure

Delta Dental will notify you if any services are denied, in whole or in part, stating the reason(s) for the denial, references to pertinent sections of the brochure, additional information you must provide to improve your claim and the procedure available for further review of your claim on *Notification of Delta Dental Benefits* which will be sent to you. Within 60 days after receipt of a notice of denial, you may make a written request for review of such denial by addressing your request to Delta Dental of New Jersey, Inc., Customer Service Department, P.O. Box 222, Parsippany, NJ 07054-0222. You must state the reason(s) you believe Delta Dental should reconsider its determination of benefits.

You must also provide:

- the name(s) and address(es) of the subscriber(s) and the patient(s);
- your Social Security number;
- the claim number(s) you request to be reviewed;
- the name of the dentist;
- the date(s) of the service(s);
- detailed description as to the basis of your appeal.

You must include any additional information or documentation which you believe may support your claim(s). Before making a formal written request for review, you are encouraged to discuss your claim with your plan administrator.

Delta Dental may require additional information for its review. Certain review requests may be referred to one of Delta Dental's consultants. Unless referral to a consultant is required or other unusual circumstances arise, you should receive a written decision on your request for review within 30 days but no longer than 60 days after Delta Dental receives your request. If special circumstances require an extension of time, a written notice of the extension will be sent to you and a decision will be made no later than 120 days after the receipt of the review. Notification of the decision will be clearly described and will specify the reasons for the decision.

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 Premier/ Advantage Program).* Also, payment for services will be sent directly to a *participating dentist*. If you are treated by a *non-participating dentist*, benefits will be paid to you, not to the *dentist.*

- 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 Estimate*s are only estimates and not a guarantee of payment. Payment 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.

- Whom can I call if I have questions about my benefits?

  You can call our Customer Service Department at (800) 452-9310 and speak to a representative Monday to Thursday, 8:00 a.m. to 7:00 p.m. EST and Friday, 8:00 a.m. to 5:00 p.m. EST. 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.

- 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.

  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*.

- 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 website at 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*.

- Is there a time limit for submitting dental claims?

  Yes, 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 more than one year from the date the service is rendered, the service is not covered.

- 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.

- If I am not located in the same state as my employers 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 8:00a.m. to 7:00 p.m. EST and Friday 8:00a.m. to 5:00p.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 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.

DELTA DENTAL

See reverse for instructions

Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (check all applicable boxes)
_ Statement of Actual Services – OR – _ Request for Predetermination/Preauthorization
_ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code
Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, NJ 07054

OTHER COVERAGE

4. Other Dental or Medical Coverage? _ No (Skip 5-11) _ Yes (Complete 5-11)

5. Members Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/YY)

7. Gender _ Male _ Female

8. Member Identifier (SSN or ID#)

9. Plan/Group Number

10. Relationship to Primary Member (Check applicable box)
_ Self _ Spouse _ Dependent Child _ Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY MEMBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/YY)

14. Gender _ Male _ Female

15. Members Identifier (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Member (check applicable box)
_ Self _ Spouse _ Dependent Child _ Other

19. Student Status
_ FTS _ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip code

21. Date of Birth (MM/DD/YY)

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/YY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) _ or Letters _	28.		31. Fee
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

MISSING TEETH INFORMATION — Permanent — Primary

34. (Place an 'X' on each missing tooth)	1 2 3 ... 14	A B C D E	F G H I J	32. Other fee(s)	
	32 31 30 29 ... 21 20 19 ...	T S R Q P	O N M L K		
				33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated ... responsible for ... charges for dental services and materials not paid by my dental benefits plan ... by law, or the treating dentist or dental practice has a contractual agreement with my pl... portion of such charges. To the extent permitted by law, I consent to your ... and disc... prot... health information to carry out payment activities in connection with this ...

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

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (check applicable box)
_ Provider's Office _ Hospital _ ECF _ Other

39. Number of Enclosures (00 to 99)
Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics?
_ No (skip 41-42) _ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/YY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis?
_ No _ Yes (Complete 44)

44. Date Prior Placement (MM/DD/YY)

45. Treatment Resulting from (Check applicable box)
_ Occupational illness/injury _ Auto accident _ Other accident

46. Date of Accident (MM/DD/YY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/member)

48. Name, Address, City, State, Zip Code

49. Provider ID

50. License Number

51. SSN or TIN

52. Phone Number ( ) -

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

1. **CONTACT INFORMATION**, including a special Customer Service toll-free phone number.
2. **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.
3. **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.
4. *NEW!* **CLAIM NUMBER INCREASED**, from 9 digits to 15.

continued on other side

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Explanation of Benefits – Dentist Copy

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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**

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

2

PAYMENT SUMMARY

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

DO NOT SEND PAYMENT TO DELTA DENTAL

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

4 *NEW!*

CLAIM NUMBER:	000000000000000
DATE OF ISSUE:	00/00/00
CHECK NUMBER:	0000000000
DENTIST ID NUMBER:	12345NJ
DENTIST NAME:	DR. JOHN SMITH
PAR STATUS:	PREMIER

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

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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

NEW!

***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.

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. 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**.

Description of Covered Services

See following page for program descriptions

	If you are in Delta Dental Premier/Advantage Program
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 (twice 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	
▪ Sealants (1st and 2nd permanent, decay-free molars, once in a lifetime per tooth, for children to age 16)	
Remaining Basic & Crowns (No Deductible)	70%
▪ Crowns and crown-related procedures (post and core, core buildup, etc., once every five years, permanent teeth only, for ages 12 and older)	
▪ Fillings – composite and amalgam (composite fillings on back teeth are given the alternate benefit of an amalgam filling, payable once per year for decay or fracture only)	
▪ Extractions, Oral Surgery (impacted wisdom teeth claims should first go to medical carrier)	
▪ Endodontics (root canals on permanent teeth and root surgery each once per 24 months)	
▪ Periodontics (have specific frequency limitations, pre-treatment estimate is strongly recommended - e.g. surgery once per 36 months)	
▪ 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)	
Prosthodontics (No Deductible)	50%
▪ 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)	

	If you are in Delta Dental Premier/Advantage Program
Calendar Year Maximum (per person)	$1,000.00
Calendar Year Deductible	
▪ Individual	N/A
▪ Family (family deductible is accumulated by individual deductibles)	N/A
At no time are you allowed two (2) maximums or subject to two (2) deductibles.	
Orthodontia (Employee and Dependents)	50%
Orthodontic treatment is a benefit limited to once in a lifetime.	
▪ Maximum (Lifetime)	$500.00
▪ Deductible (Lifetime)	N/A

Description of Program

Delta Dental Premier/Advantage Program - 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 first of the month following 60 days of continuous full-time employment.

Eligible Dependents

- Your spouse.
- 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 2 to 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.
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 Premier/Advantage Program	Delta Dental's enhanced preferred provider option (PPO) where the patient receives the benefits of the Advantage program when the patient is treated by an Advantage dentist and the advantages of the Delta Dental Premier program when the patient is treated by a Delta Dental Premier dentist who does not participate in the Advantage 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 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.
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 Premier/Advantage Program

Delta Dental Premier/Advantage Program offers access to both Delta Dental Premier and Advantage Program dentists. Where the eligible patient is treated by an Advantage Program dentist, the fee for the covered service(s) will not exceed the Advantage plan's maximum allowable charge(s). Where the eligible patient is treated by a Delta Dental Premier dentist who does not participate in the Advantage Program or by a *Participating Specialist*, you receive payment based on the Delta Dental Premier Program and the dentist has agreed not to charge you more than the dentist's filed fee or Delta Dental's established UCR for the procedure(s). Claims for service(s) provided by dentists who are neither Delta Dental Premier, Advantage Program dentists, or *Participating Specialists* are paid based on the lesser of the dentist's actual charge or the prevailing fee as determined by Delta Dental.

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.

Notes:

P. O. Box 222
Parsippany, NJ 07054-0222

800-452-9310

www.deltadentalnj.com

The Plan That Keeps You Smiling.