Blue Cross and Blue Shield of New Jersey

GRINSPEC TRUST
Chesterfield Township BOE

#98028

Your Dental Care Program

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INTRODUCTION

This booklet describes your Dental program which is underwritten by Blue Cross and Blue Shield of New Jersey, Inc. and summarizes the benefits and essential details of this program.

We suggest that you read this booklet carefully to become familiar with the coverage afforded you by the Dental Program.

This booklet replaces any booklets or certificates you may have received previously.

DEFINITIONS

This section defines certain important words used in this booklet. The meaning of each defined word, whenever it appears in this booklet, is governed by its definition as listed in this section.

We, Us, Our and the Plan. Blue Cross and Blue Shield of New Jersey, Inc.

Dentist. Any dentist licensed to practice dentistry. A dentist also means any physician licensed to practice medicine and surgery who is performing procedures common to both the medical and dental professions. This includes both doctors of medicine and doctors of osteopathy.

Participating Dentist. A state-licensed dentist who has a written agreement with us to perform services and receive payment under this program.

Non-Participating Dentist. A state-licensed dentist who does not have such an agreement with us.

Certified Registered Nurse Anesthetist (C.R.N.A.). A registered Nurse, certified to administer anesthesia, who is employed by and is under the personal supervision of a physician anesthesiologist.

Treatment Plan. A written report prepared by a dentist showing the dentist's recommended treatment of any dental disease, defect or injury.

Service Report. A claim form showing the information about the employee, the eligible person receiving services, and the services performed by the Dentist.

How To Enroll

You may enroll in the Blue Cross and Blue Shield of New Jersey, Inc. Dental program by completing an enrollment card.

If you don't apply for coverage for yourself when you first become eligible (or if you end your coverage), you must wait for a later open enrollment period to enroll, and the effective date of this open enrollment period must be at least 18 months after the last time you could have obtained coverage, or at least 18 months after the date you ended your coverage.

Your Identification Card

You will receive a Dental identification card to show to the dentist when you need to use your Dental benefits. Your identification card shows the group through which you are enrolled, your type of coverage, your identification number and the effective date when you can start to use your benefits.

Always carry this card and use your identification number when you receive eligible services. If you lose your card, you can still use your coverage if you know your identification number. The inside back cover of this booklet has space to record your identification number along with other information you will need when making inquiries about your benefits. You should, however, contact your enrollment official immediately to replace any lost card.

You cannot let anyone not named in your coverage use your card. Nor can you let anyone who is not named in your coverage use your benefits or receive payment for them.

When Benefits Begin

Your benefits begin on the effective date shown on your identification card.

Types Of Enrollment Available

You may enroll under one of the following types of coverage:

- **Single** - provides coverage only for yourself.

When Your Coverage Ends

Your coverage ends on the last day of the benefit month in which your enrollment in this program ends, or on the last day of the benefit month for which premium charges have been paid by your group.

If You Leave Your Group Due To Total Disability

If you can no longer be employed due to a total disability, you can arrange to continue coverage through your group if:

- You were continuously enrolled under the group program for the three months immediately prior to your loss of employment;
- You notify your employer that you want to continue your group coverage within 31 days of the date your coverage would normally end;
- You continue to pay any premiums required for the coverage by your employer.

However, continued coverage under this program for you will end at the first to occur of the following:

- Failure by you to make timely payment of any contribution required by your employer. If this happens, coverage will end at the end of the period for which contributions were made;
- The date you become employed and eligible for benefits under another employer's health plan;
- The date this program ends.

If you are a ***totally disabled*** former employee whose group coverage has been continued without interruption in accordance with state law, through the employer's prior health insurance carrier, you will also be eligible for coverage under this program. Such coverage will be continued until the former employee no longer meets the eligibility requirements described above.

Totally disabled means that due to injury or illness, as determined by us:

- You are unable to engage in your regular occupation and are not, in fact, engaged in any employment for wage or profit.

Extension Of Dental Coverage Due To Incomplete Services

Benefits for eligible services under the Dental program will be provided after the date a person is no longer eligible under the program for any individual procedure which began prior to termination and is completed within 30 days after coverage ends.

Extension Of Coverage Due To Group Termination

If you are totally disabled on the date coverage for your group ends, we will pay for your covered dental services which began before the date the contract ended and continued after that date, but only up to 90 days from the day the person received the first dental service.

YOUR DENTAL BENEFITS

This section describes the dental services that are covered for you . To be eligible for coverage, a service must be necessary for the prevention, treatment or diagnosis of a dental disease, injury or condition.

Submission of a treatment plan is suggested for some services. If submission of a treatment plan is suggested, we recommend pre-determination by us *before* the service is performed.

Eligible Services

Preventive/Diagnostic Services

You are eligible for the following benefits:

- Examinations 3 times a year;
- Bitewing X-rays twice a year and full mouth X-rays once every 36 months;
- Prophylaxis including scaling and polishing 3 times a year;
- Topical application of fluoride for persons under age 19, limited to once every six months.
- Palliative Treatment;
- *Space maintainers (for children under age 19).

Therapy/Treatment Services

You are eligible for the following benefits:

- Repair of dentures;
- Fillings consisting of silver amalgam and synthetic restorations;
- Biopsy of oral tissue;
- Pulp capping and pulpectomy;
- Simple extractions (Submission of pre-operative X-rays and a treatment plan is suggested for three or more extractions);
- *Endodontics, root canal therapy;

**It is suggested that a treatment plan and pre-operative X-rays be submitted before services are performed. Endodontics and root canal therapy require post-operative X-rays.*

General anesthesia for a covered dental service is eligible when dentally necessary. The anesthesia must be administered and billed for by a dentist or physician other than the operating dentist, or by a certified registered nurse anesthetist employed by and personally supervised by a physician anesthesiologist. This benefit includes the administration of anesthetics by injection or inhalation, but not local anesthesia. Examinations, consultations and other necessary care an anesthesiologist gives - before, during and after the operation - are all included in the payment for anesthesia service.

Prosthodontic Benefits (Submission of a treatment plan and pre-operative X-rays is suggested)

Prosthodontic benefits include:

- Partial or complete dentures;
- Fixed bridges;
- Abutement Crowns and Pontics.

No benefits will be provided for:

- Replacement of dentures or bridges within 5 years after receiving these services;
- Replacement of dentures or bridges due to loss or theft;
- Replacement of any denture or bridge that is satisfactory or can be made satisfactory;
- Relining or rebasing initial or replacement dentures if the services are performed within 6 months after insertion of the denture, or for more than one relining or rebasing in any 36-month period.

Periodontic Benefits

Periodontic benefits include:

- Surgical periodontic examination;
- Gingival curettage;
- Periodontal maintenance
- *Management of acute infections and oral lesions;
- *Gingivectomy and gingivoplasty;
- *Osseous surgery, including flap entry and closure;
- *Mucogingivoplastic surgery;
- *Other periodontal procedures as determined by us.

**It is suggested that a treatment plan and pre-operative X-rays be submitted before services are performed.*

Onlay And Crown Benefits

Onlay and Crown benefits include:

- Onlays and crowns for restorative purposes that are not splinted or part of a bridge (Submission of a treatment plan and pre-operative X-rays is suggested).

No benefits will be provided for:

- Replacement of crowns or onlays within 5 years after receiving these services;
- Replacement of any crown or onlay that is satisfactory or could be made satisfactory;
- Single, unconnected crowns and onlays if the tooth can be restored by any other material. If we decide the tooth can be restored with another material, payment will be the allowance toward the charge for a single crown or onlay.

Oral Surgery Benefits

Oral surgery benefits include:

- Alveolectomy;
- *Surgical extractions (Submission of a treatment plan for three or more extractions is suggested, unless the services are done in an emergency);
- *Treatment of fractures;
- *Removal of lesions;
- *Apicoectomy;

**It is suggested that pre-operative X-rays be submitted before services are performed, except for removal of soft-tissue tumors.*

How To Obtain Benefits

When you go to the dentist, show your Dental program identification card. Be sure to discuss charges and payment with the dentist before services begin. If submission of a treatment plan for any services is suggested, have the dentist complete the treatment plan portion of the claim form. Both you and your dentist will receive our Pre-determination indicating possible allowances. *This is not a guarantee of payment but an estimate of the benefits available for the proposed services to be rendered. The submission of additional claims or the revision of a pre-certified treatment plan prior to the final payment of this claim may affect the estimate given on the Pre-determination.*

After services are completed, the dentist sends the completed claim form to us. Participating dentists are paid directly for covered services, unless you have already paid the dentist. If services are performed by a non-participating dentist, payment for covered services will be made directly to you. Whenever payment is made to the dentist, you will be notified of the amount of the payment.

Participating dentists should have the necessary claim forms. If your dentist does not have them, you can get them from your enrollment official or from us.

Basis Of Payment

Payment under your Dental program will be made based on the fees agreed upon between us and our participating dentists. Coinsurance levels for dental services are as follows:

- 100% of the allowable charge for Preventive/Diagnostic Services;
- 80% of the allowable charge for Therapy/Treatment Services;
- 50% of the allowable charge for Prosthodontic Benefits;
- 80% of the allowable charge for Periodontic Benefits;
- 80% of the allowable charge for Onlay and Crown Benefits;
- 80% of the allowable charge for Oral Surgery Benefits;

For any of the percentages shown above that are less than 100%, a participating dentist may bill you for the difference up to the 100% of the allowable charge. A participating dentist must accept 100% of the allowable charge as payment in full. If your dentist does not participate with us, you must pay the difference between our payment and the dentist's charge, even if it exceeds the the Usual, Customary and Reasonable (UCR) charge. If your dentist charges less than the allowable charge, we will pay the percentage shown above of the actual charge.

Deductible

There is no deductible for group #98028, Chesterfield Township Board of Education.

Benefit Period

The benefit period is each calendar year commencing January 1. Should a condition continue beyond December 31, the current benefit period would end and a new benefit period with a new deductible would begin.

Maximum Payment

We will pay benefits for covered dental expenses up to ~~$1,500~~ $2,000- during each calendar year, as long as this program is in effect. This maximum is combined for all services.

EXCLUSIONS UNDER YOUR DENTAL PROGRAM

The following *exclusions* apply to your Dental program:

- Services provided by an assistant surgeon;
- Services with fees payable to a hospital or other institution; all hospital services;
- Services not dentally necessary, as determined by our dental staff or consultants. To be eligible for coverage, a service must be required for the prevention, diagnosis or treatment of a dental disease, injury or condition. The fact that a procedure is prescribed by your dentist does not make it dentally necessary or eligible under this program. We can ask for any proof we require (such as X-rays or study models) to decide whether services are dentally necessary. If you or your dentist fail to provide this proof, we can adjust or deny payment for any services performed;
- Anesthesia or consultation services when given in connection with any service that is not covered;
- Services performed by a hospital resident, intern or dentist who is paid by a hospital or other source, or who is not permitted to charge for services covered under this program; or by anyone who does not qualify as a dentist as defined in this booklet;
- Services Performed by an Immediate Relative. The Plan does not provide benefits for services that are performed by an immediate relative of the Eligible Person unless specifically stated in the benefit exhibits;
- Implantology;
- Educational services, such as oral hygiene or dietary instructions;
- Services in connection with plaque control programs;
- Duplicate space maintainers;
- Services performed or items furnished strictly for cosmetic purposes;
- Any service or item which requires a treatment plan if our approval was not obtained prior to the rendering of the service or item, unless done in an emergency;
- Gold foil restorations;
- Any services not specifically listed as covered under this program.
- Any charges incurred for, or in connection with Cosmetic surgery, procedures, treatment, drugs or biological products;
- Any investigative or experimental procedures, treatments, facilities, equipment, drugs, devices or supplies.

In addition, the following *restrictions* apply:

a. Care rendered by more than one dentist - In the event an eligible person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, we will be liable for no more than the amount for which we would have been liable had but one dentist rendered the service.

b. Alternative course of treatment - In all cases involving services in which the dentist or the eligible person selects a course of treatment, benefits will be based on the procedure that is consistent with sound professional standards of dental practice for the dental condition concerned and which carries a lesser fee.

SERVICES FOR AUTOMOBILE RELATED INJURIES

Under this program, the Plan will provide secondary coverage to PIP unless the Plan has been elected as primary coverage by or for the Eligible Person covered under this contract. This election is made by the named insured under the PIP policy and affects that person's family members who are not themselves the named insured under another auto policy. The Plan may be primary for one Eligible Person, but not for another if the persons have separate auto policies and have made different selections regarding primacy of health coverage.

The Plan is secondary to Other Automobile Insurance Coverage. However, if the Other Automobile Insurance contains provisions which made it secondary or excess to the Plan, then the Plan will be primary.

If there is a dispute as to whether the Plan is primary or secondary, the Plan will pay benefits as if it were primary.

If the Plan is primary to PIP or other Automobile Insurance Coverage, it will pay benefits subject to the terms, conditions and limits set forth in your Contract and only for those services normally covered under your Contract.

If the Plan is one of several health insurance plans which provide benefits for Automobile Related Injuries and the Eligible Person has elected health coverage as primary, these plans may coordinate benefits as they normally would in the absence of this provision.

If the Plan is secondary to PIP, the actual benefits payable will be the lesser of:

a) the remaining uncovered allowable expenses after PIP has provided coverage after application of copayments, or

b) the actual benefits that would have been payable had the Plan been providing coverage primary to PIP.

CLAIMS APPEAL

You or your authorized representative may appeal and request us to reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the limitations and/or exclusions of your program.

For ***Dental*** claims, send your request to Blue Cross and Blue Shield of New Jersey, Inc., Dental Program, P.O. Box 1938, Newark, New Jersey 07101-1938.
For each Dental request, include the following information:

- Name(s) and address(es) of patient and subscriber;
- Subscriber's Dental program identification number;
- Date(s) of service(s);
- Claim number;
- Name and address of dentist;
- Reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim which was not given to us when the claim was first submitted, be sure to include it.

Upon request, you have the right to review pertinent documents. Copies of your group's contract are available from your employer. A copy of other material relative to your claim will be made available from us. In some cases, written authorization from your attending physician to release certain information will be necessary and you will be informed accordingly.

Inquiries should be made within 12 months of the date you were first notified of the action taken to deny all or part of your claim. Upon receipt of the written inquiry, your claim will be researched and reviewed thoroughly and you will be notified of the decision on your appeal within 60 days of receipt of the appeal. However, special circumstances, such as delays by you or the provider in submitting necessary information, may require an extension of this 60-day period.

If legal action is brought against us for a claim that has been wholly or partially denied, the action must be brought within 12 months of the first denial, or if the claim has been appealed, within 12 months of the denial of the appeal.

When you need to call us, identify yourself and the group program through which you are enrolled. Also give your group number and your identification number. Space is provided to write in names, addresses and phone numbers on the last page of this booklet.

COORDINATION OF BENEFITS

Almost all group insurance programs provide for the coordination of benefits. A program without such a provision is automatically the primary program whenever its benefits are duplicated. For programs that do have this provision, the following rules determine which one is the primary program:

- If you are the patient, then this program is the primary program. If your spouse is the patient and covered under a program of his or her own, then that program is the primary program.
- If a dependent child is the patient and is covered under both parents' programs, the following birthday rule will apply:

Under the birthday rule, the plan covering the parent whose birthday falls earlier in the year will have primary responsibility for the coverage of the dependent children. For example, if the father's birthday is July 16 and the mother's birthday is May 17, the mother's plan would be the primary for the couple's dependent children because the mother's birthday falls earlier in the year. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary. ***Only the month and the day (not the year) of each parent's birthday is used to determine which plan is primary.***

This birthday rule regulation affects all carriers and all contracts which contain COB provisions. It applies only if both contracts being coordinated have the birthday rule provision. If only one contract has the birthday rule and the other has the gender rule (father's contract is always primary), the contract with the gender rule will prevail in determining primary coverage.

- If two or more programs cover a person as a dependent child of separated or divorced parents, benefits for the dependent child will be determined in the following order:

    - The program of the parent with custody is primary;
    - The program of the spouse of the parent with custody of the child;
    - The program of the parent not having custody of the child. However, if it has been established by a court decree that one parent has responsibility for the child's health care expenses, then the program of that parent is primary.

The benefits of the program which covers a person as an active employee or his dependents will be determined before the benefits of a program which covers such person as a laid-off or retired employee or his dependent. If the other benefit program does not have this rule and, as a result, do not agree on the order of benefits, this rule will not apply.

- If none of the above rules determine the order of benefits, the program that has covered the patient for the longer period is the primary program.

This program will provide its regular benefits in full when it is the primary plan. As a secondary plan, this program will provide a reduced amount which when added to the benefits under other group plans will equal up to 100% of the charges for the patient's eligible expenses under this program, but in no event will this program's liability as a secondary plan exceed its liability as a primary plan.

SERVICE CENTERS

If you have any questions about this program, call our Service Center.

Telephone personnel are available Monday through Friday from 8:00 a.m. to 8:00 p.m. and on Saturdays from 8:00 a.m. to 1:00 p.m.

For ***Dental***, call:

1-(800)-4DENTAL

Always have your identification card handy when calling us. Your ID number helps us get prompt answers to your questions about enrollment, benefits or claims.

Use this space for information you will need when asking about your coverage.

The company office or enrollment official to contact about coverage:

_____

The identification number shown on my identification card:

_____

The effective date when my coverage begins:

_____

My group number is:

_____

The benefits described are subject to all the terms, conditions, limitations and definitions in the contract, as well as all provisions required by State Law.

In the event there appears to be a contradiction between the benefits described in this booklet and those provided in the group contract, the group contract shall prevail.