
Horizon®
Horizon Blue Cross Blue Shield of New Jersey

This booklet contains only a general description of the benefits available to you under your employer's dental program. The benefits described are subject to all the terms, conditions, limitations and definitions contained in the Plan Document.

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

Jackson Township BOE

Horizon DOP Plan
008512J-045

Summary Plan Description

Administered By

Horizon Blue Cross Blue Shield of New Jersey

Horizon Healthcare Dental Services, Inc.

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SUMMARY PLAN DESCRIPTION

The following information, together with the information contained elsewhere in this booklet, comprise the summary plan description required by Section 102 of the Employee Retirement Income Security Act of 1974 (ERISA).

Every effort has been made to be informative about the benefits available under the Plan, what you must do to obtain those benefits and the terms, limitations, exclusions or provisions which could cause a benefit to be reduced or denied. In any event, where a question may arise as to a claim for benefits or the reduction or denial of a claim for benefits, the Plan Sponsor/Administrator, the Claims Administrator and such other individuals associated with the Plan shall be guided solely by this Summary Plan Description, which is also the Plan Document.

PLAN NAME:
Jackson Township BOE. Horizon DOP Plan

PLAN SPONSOR:
Jackson Township BOE

PLAN ADMINISTRATOR:
Jackson Township BOE

EMPLOYER IDENTIFICATION NUMBER:
21-6000344

PLAN NUMBER:

FUNDING METHOD:
Self-Funded

PLAN EFFECTIVE DATE: **LATEST REVISION DATE**
July 1, 2019

TYPE OF PLAN:

ASO

PLAN ADMINISTRATOR AUTHORITY AND POWERS:

The Plan Administrator shall have exclusive discretionary authority and power to determine eligibility for benefits and to construe the terms and provisions of this Plan, to determine questions of fact and law arising under this Plan, and to exercise all of the powers necessary for the operation of this Plan.

FISCAL RECORDS:

Records of this Plan are maintained on a Plan year basis, ending on December 31 of each year.

AGENT FOR SERVICE OF LEGAL PROCESS:

Service of process may also be made upon the Plan Administrator.

CLAIMS ADMINISTRATOR:

The Claims Administrator provides services for the Plan Administrator, including maintenance of eligibility files, issuance of employee identification cards, processing and payment of claims and such other services as may be delegated by the Plan Administrator. This Plan's Claims Administrator is:

Horizon Blue Cross Blue Shield of New Jersey
Horizon Healthcare Dental Services, Inc.
3 Penn Plaza East
Newark, NJ 07105

GROUP NUMBER:

The group number assigned by the Claims Administrator is: 008512J.

PLAN COSTS:

PLAN ELIGIBILITY REQUIREMENT:

All regular full-time employees of the Plan Sponsor who work a minimum of 25 hours per week are eligible for coverage upon completion of the employment waiting period which is until the first of the month coincident with or next following: 1st of the Month following 30 days of Employment. Dependents of eligible employees can be covered under this plan if they are either the employee's legal spouse or eligible unmarried dependent child.

CAUSES FOR INELIGIBILITY (Summary Only):

Termination of this plan, employment or eligibility as a dependent or a failure to make required contributions or work the required minimum number of hours. Certain individuals (Qualified Beneficiaries) who become ineligible for benefits under this plan may be allowed to continue coverage under the terms of COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985).

PLAN BENEFITS:

Dental expense coverage as described in this booklet.

PLAN PROVISIONS LIMITING BENEFITS (Summary Only):

Deductible and/or coinsurance, late enrollment, frequency of some services, coordination of benefits and plan maximums.

CLAIM INFORMATION:

The Human Resources Department has a supply of Dental Service Report forms to be used with this plan. Participating dentists will file claims on your behalf and be directly reimbursed by the plan. Non Participating dentists may or may not file claims on your behalf and plan payment will be made directly to you. Whenever payment is made to any dentist, you will be notified of the amount of the payment.

If a claim has been denied or partially denied, the employee can ask to have the claim reviewed. The Horizon Claims Appeal process is described in more detail on page 18 of this booklet. If the employee or the employee's authorized representative has any additional information or evidence about the claim which was not given at the time the claim was first submitted, be sure to include it with any appeal. A request for review should be made to Horizon within 180 days of the date the employee was first notified of the denial or partial denial. Upon receipt of the employee's request, the claim will be reviewed. The employee will be notified of Horizon's decision within 30 days of its receipt. However, special circumstances, such as delays by the employee or dentist in submitting necessary information, may require an extension of this 30 day period. If this happens, the employee will be notified.

Upon request, the employee or their authorized representative may review documents pertinent to the claim and submit issues and comments in writing. Copies of the documents are available from the Plan Administrator or Horizon.

If the employee's claim is again denied after Horizon's review, or if the employee does not wish for Horizon to review the claim, the employee may appeal to the Plan Administrator. The employee must appeal to the Plan Administrator within 60 days of the receipt of the latest claim denial. Within 45 days after receipt of a request for review, the Plan Administrator will furnish a written decision. The written decision will set out the specific reason(s) for the decision and the provision(s) of the plan on which the decision is based. If it is determined that benefits are due, payment will be made promptly. In all instances, the Plan Administrator has the right, in its discretion, to interpret and apply the plan, and to make all eligibility, benefit and payment determinations. The Plan Administrators decision, and the Plan Administrators exercise of discretion, will be final and binding on all parties.

PLAN MODIFICATION/TERMINATION INFORMATION:

Not withstanding anything to the contrary in this Summary Plan Description, the Plan Sponsor/ Administrator expressly reserves the right, at any time, for any reason and without limitation to terminate, modify or otherwise amend this plan and any or all of the benefits provided thereunder, either in whole or in part, whether to all persons covered thereby or one or more groups thereof. These rights include specifically, but are not limited to, (1) the right to terminate benefits under the plan with respect to any participant therein; (2) the right to modify benefits under this plan to all or any group of participants therein; (3) the right to require or increase contributions by any participants therein towards the cost of this plan; and (4) the right to amend this plan or any term or condition thereof; in each case, whether or not such rights are exercised with respect to any other participant or group of participants in this plan.

The termination, modification or other amendment of this plan shall be effected by written authorization signed by the designated official of the Plan Sponsor/Administrator.

STATEMENT OF ERISA RIGHTS

As a participant in the DOP Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all plan documents and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of this plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and the other plan participants and beneficiaries.

No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

SCHEDULE OF DENTAL BENEFITS

This is a brief summary of the eligible services and Plan payments for covered dental services.

TYPE OF SERVICE	PLAN PAYMENT
I. **Preventive and Diagnostic** ● examinations ● prophylaxis - teeth cleaning ● fluoride treatment (for persons under age 19 only) ● x-rays	100%
II. **Treatment/Therapy** ● restorative - fillings ● simple extractions ● repair of dentures ● endodontics - root canal therapy	100%
Periodontics ● periodontal cleaning ● gum disease treatment	80%
Oral Surgery ● surgical extractions ● removal of lesions ● treatment of fractures	80%
III. **Prosthodontics** ● partial or complete dentures ● fixed bridges ● abutment crowns	50%
Onlays and Crowns ● single crowns and onlays (for persons under age 19 only)	80%
IV. **Orthodontics** ● active treatment including appliances (for persons under age 19 only)	50%

Deductible:	$25.00 per person, maximum of $75.00 per family, per calendar year. Deductible does not apply to Preventive/Diagnostic or Orthodontic Services. Out of Network Deductible is $25.00 per person, maximum of $75.00 per family. Does not apply to Orthodontics.
Benefits Maximums:	Types I, II & III: $1,000.00 per person, per calendar year. Type IV: $1000.00 per person per lifetime

HOW THE DOP PLAN WORKS

Freedom Of Choice

The Horizon DOP Plan is designed to allow you freedom of choice each time you need covered dental services, but the choices you make will affect the Plan's reimbursements and your out-of-pocket costs. You can choose a Participating Dentist from Horizon Blue Cross Blue Shield of New Jersey's Directory of Participating Dentists, or you can choose a Non Participating Dentist. Regardless of whether you choose a Participating or Non Participating Dentist, the Plan's deductibles, coinsurance and benefit maximums remain the same.

Participating Dentists

Participating Dentists have an agreement with Horizon to accept Horizon's Maximum Allowable Charges as payment in full. Dentists can participate in either the Horizon Traditional or PPO network. Regardless of which type of Participating Dentist you choose, you will only be responsible for the Plan's deductible or coinsurance amounts, the Dentist cannot balance bill you for any difference between their normal charges and Our Maximum Allowable Charges. Generally, Participating Dentists will submit your claims and be directly reimbursed by Horizon.

You may choose one of the Dentists who have agreed to participate in the Horizon PPO network. An asterisk by the Dentist's name in the directory indicates that they participate in the Horizon PPO network. Horizon PPO Participating Dentists have agreed to discounted Maximum Allowable Charges which are significantly below their normal charges. Since both the Plan's reimbursement and your coinsurance amount are based on the discounted Maximum Allowable Charges, you will maximize the Plan's benefits and minimize your out-of-pocket costs when using a Horizon PPO Dentist.

Horizon Traditional Dentists: You may choose one of the Dentists who have agreed to participate in the Horizon Traditional Network. Horizon Traditional Dentists have agreed to accept discounted Maximum Allowable Charges, but the discounts are not as significant as those of the Horizon PPO Dentists.

Non Participating Dentists

A Non Participating Dentist is any licensed Dentist who does not have an agreement with Horizon Blue Cross Blue Shield of New Jersey. You have the freedom to choose a Non Participating Dentist, but since they have not agreed to any discount from their normal charges, your out-of-pocket costs may be higher. The Plan will reimburse a Non Participating Dentist based on the lesser of their normal charges or the Plan's Maximum Allowable Charges. You would be responsible for not only the Plan's deductible and coinsurance amounts, but any balance the Dentist may bill for their normal charges which are in excess of the Plan's Maximum Allowable Charges. Since the Plan's reimbursements will be paid directly to you, Non Participating Dentists may require you to pay the entire bill in advance and submit your own claim forms.

For more information and details on the benefit Plan, please review this booklet carefully.

INTRODUCTION

This summary plan description booklet describes the benefits and other essential provisions of Jackson Township BOE Horizon DOP Plan. We encourage you to read this booklet carefully to become familiar with the coverage and benefits afforded you by the **Plan**.

If, after a review of the booklet, you have general questions about this **Plan**, contact Human Resources at **(999) 999-9999**. If you have questions concerning claims or benefit payments, you should directly contact the Claims Administrator, Horizon Blue Cross Blue Shield of New Jersey at **1-800-4DENTAL.**

The **Plan** described in this summary plan description booklet was effective as of July 1, 2019 and benefits have not been materially changed since then. Since this booklet contains valuable information about this Plan, you should keep it handy for reference.

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.

The Plan. Jackson Township BOE. Horizon DOP Plan

We, Us, and Our. Horizon Blue Cross Blue Shield of New Jersey.

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 receives payment under this program.

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

Maximum Allowable Charges (MAC). The maximum amount on which the Plan's reimbursements will be based. For Participating Dentists, the Maximum Allowable Charge for any covered service is the Horizon Blue Cross Blue Shield of New Jersey Maximum Allowable Charge to which they've agreed. For Non-Participating Dentists, the Maximum Allowable Charge is the lesser of the Dentist's normal charge for any covered service or the maximum allowance set by the Plan for that service for that group.

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.

GENERAL INFORMATION

How To Enroll

You may enroll in this dental Plan by completing an enrollment application. If you enroll your dependents, their coverage will become effective on the same date as your own.

If you don't apply for coverage for yourself or your dependents when you first become eligible (or if you end your coverage), you must wait until the next open enrollment period to enroll.

Open Enrollment Period

Each year, an open enrollment period takes place in May.

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. All of your eligible dependents share your identification number.

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 Human Resources Department 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;
- **Parent and Child(ren):** provides coverage for you and your eligible children but not your spouse;
- **Husband and Wife:** provides coverage for you and your spouse but not your child(ren);
- **Family:** provides coverage for you, your spouse and your eligible children.

Eligible Dependents

Your eligible dependents are your spouse and your unmarried children under age 19. We consider your children dependents if they are your own, your spouse's natural children, your legally adopted children or a child placed in your home for whom you have begun adoption procedures, or children living with you for whom you are appointed legal guardian by a court and for whom you are financially responsible. Foster children are not included.

Although a child born to unmarried parents is eligible to be enrolled as a dependent, the child must reside with you. The residency requirement may be waived if a court decree makes you financially responsible for the child's health care expenses. Also, if the child's last name is different than yours, a birth certificate naming you as parent must also be received by us.

Coverage for a child ends on the last day of the calendar month in which the child marries or the last day of the Calendar Month in which the child attains age 19, whichever comes first.

In addition, an unmarried handicapped child may remain covered beyond age 19. A handicapped child is one who is incapable of self-sustaining employment because of mental retardation or physical handicap. The child's handicap must have started before he or she became age 19 and the child must depend chiefly on you for support.

For the handicapped child to remain covered, you must give us proof of the child's incapacity within 31 days of the date on which the child becomes age 19 The proof must be in a form which meets our approval.

Once we receive acceptable proof of the handicap, that child can remain covered as long as the Family or Parent and Child(ren) contract is in effect and the handicap continues to exist. Coverage will end on the last day of the benefit year in which the child ceases to qualify as a handicapped child.

Student Dependent Coverage

Eligible unmarried child dependents between the ages of 19 and 23 who are full-time students at an accredited institution of higher education are included for dependent coverage until the last day of the Calendar Month in which their 23 birthday occurs.

When the child no longer qualifies as a student, coverage will end on the last day of the benefit month in which qualification ceases to be met.

Change In Type Of Coverage

If you want to change your type of coverage, see your enrollment official. If you marry, you should arrange for enrollment changes within 31 days before or after your marriage.

If you gain or lose a member of your family or whenever someone covered under this program changes family status, you should check this booklet to see if coverage should be changed. This can happen in many ways: for example, through the birth or adoption of a child, or the divorce or death of a spouse.

- If you already are enrolled under Family or Parent and Child(ren) coverage, your newborn infant is automatically included;

- If you have Single coverage, your newborn will be eligible from the date of birth if you apply for Family or Parent and Child(ren) coverage within 31 days of birth;

- If you apply for coverage for your newborn between the 32nd and 90th day after the birth, the coverage will be effective on the first day of the month after the date the application was received.

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.

Coverage for a dependent will end when your coverage ends, or on the day on which the dependent fails to meet the definition of a dependent, or in the case of an unmarried child, on the last day of the benefit month in which the termination age is reached.

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 (including coverage for dependents) 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 and your eligible dependents 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 or, in the case of an eligible dependent, the date the dependent becomes employed and eligible for such benefits

- The date this program ends.

If you are a *totally disabled* former employee whose group coverage (including coverage for any eligible dependents) 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; or

- Your dependent is unable to engage in the normal activities of a person of like age and sex in good health.

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 or a member of your family is totally disabled on the date coverage for your group ends, we will pay for that person's 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.

Continuing Protection For Surviving Dependents

Eligible dependents of a deceased subscriber may have coverage continued under this program for at least 180 days after the subscriber's death. See your enrollment official for further details and to arrange to make any required premium payments through the group.

Continuation Of Coverage Under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you may have the opportunity to continue group dental coverage which would otherwise end.

Your employer is responsible for providing all notices required with respect to this provision. Contact your employer for any rights for continuation of dental coverage under COBRA.

Continuation of Coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If the Employee is absent from work due to performing service in the uniformed services, this federal law gives the Employee the right to elect to continue the health coverage under this Policy (for himself/herself and the Employee's Dependents, if any). If the Employee so elects, the coverage can be continued, subject to the payment of any required contributions, until the first to occur of the following:

- The end of the 24-month period starting on the date the Employee was first absent from work due to the service.
- The date on which the Employee fails to return to work after completing service in the uniformed services, or fails to apply for reemployment after completing service in the uniformed services.
- The date on which this Policy ends.

If the Employee elects to continue the coverage, the Employee's contributions for it are determined as follows:

a) If the Employee's service in the uniformed services is less than 31 days, his/her contribution for the coverage will be the same as if there were no absence from work.

b) If the service extends for 31 or more days, the Employee's contribution for the coverage can be up to 102% of the full premium for it.

For the purposes of this provision, the terms "uniformed services" and "service in the uniformed services" have the following meanings:

Uniformed services: The following:

1. The Armed Services.
2. The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty.
3. The commissioned corps of the Public Health Service.
4. Any other category of persons designated by the President in time of war or national emergency.

Service in the uniformed services: The performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority. This includes:

1. Active duty.
2. Active and inactive duty for training.
3. National Guard duty under federal statute.
4. A period for which a person is absent from employment: (a) for an exam to determine the fitness of the person to perform any such duty; or (b) to perform funeral honors duty authorized by law.
5. Service as: (a) an intermittent disaster-response appointee upon activation of the National Disaster Medical System (NDMS); or (b) a participant in an authorized training program in support of the mission of the NDMS.

Continued Coverage Pursuant to Michelle's Law

This provision applies to a Child Dependent who was a Covered Person under the Policy on the basis of being a student at a postsecondary educational institution (e.g., a college, university or vocational school) immediately before the first day of a Medically Necessary Leave of Absence.

For the purpose of this provision, a Medically Necessary Leave of Absence is a leave of absence from the postsecondary educational institution, or any other change in the Child Dependent's enrollment in the institution, that:

a) starts while the Child Dependent is suffering from a serious illness or injury:

b) is medically necessary; and
c) causes the Child Dependent to lose student status for the purposes of the coverage under the Policy.

Pursuant to the federal "Michelle's Law" and regardless of anything in the Policy to the contrary, if the Child Dependent's physician certifies in writing to Horizon that: (i) the Child Dependent is suffering from a serious illness or injury; and (ii) the leave of absence or other change in enrollment is medically necessary, then the Child Dependent's coverage under the Policy shall not end until the first to occur of the following:

1. the date on which the Child Dependent's coverage under the Policy would otherwise end, e.g., due to the termination of the Policy, or due to the Child Dependent's attainment of a maximum age limit;
2. the Medically Necessary Leave of Absence ends without a return of the Child Dependent to a student status that meets the Policy's rules;
3. the date that is one year after the first day of the Medically Necessary Leave of Absence.

YOUR DENTAL BENEFITS

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

Eligible Services

Preventive/Diagnostic Services

You are eligible for the following benefits:

- Comprehensive, limited and non-routine oral examinations, including consultations, 3 every Calendar Year.
- Bitewing X-rays once every six months and full mouth X-rays once every 36 months
- Prophylaxis including scaling and polishing once every six months
- Topical application of fluoride for persons under age 19 limited to once every six months
- Sealants (eligible for children up to 14 years of age), limited to permanent posterior molars.

Therapy/Treatment Services

You are eligible for the following benefits:

- Repair of bridges;
- Fillings consisting of silver amalgam and synthetic restorations;
- Acrylic, plastic and stainless steel crowns;
- Emergency dental services;
- 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;
- *Space maintainers (for children under age 19), limited to treatment for premature loss of deciduous teeth.

**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.*

Oral Surgery Services

You are eligible for the following benefits:

- 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;
- Appliances for minor tooth movement (Submission of a treatment plan is suggested unless the services are done in an emergency).

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

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 Dentist 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.

Periodontic Services

You are eligible for the following benefits:

- Surgical periodontic examination;
- Gingival curettage;
- *Periodontal maintenance procedures, following active therapy and a period of at least three months has elapsed since surgery was performed;
- Management of acute infections and oral lesions;
- *Osseous surgery, including flap entry and closure. Any surgical procedure performed on the same date as osseous surgery will not be an eligible service;
- *Mucogingivoplastic surgery;
- *Occlusal adjustments, but only when performed within three months of definitive periodontal treatment;
- *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 Services

You are eligible for the following benefits:

- 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 before any services are performed).

***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.

Prosthodontic Services
(Submission of a treatment plan and pre-operative X-rays is suggested before any services are performed)

You are eligible for the following benefits:

- Partial or complete dentures;
- Adjustments to dentures, including rebasing or relining;
- Fixed bridges;
- Abutment Crowns and Pontics.

***No* benefits will be provided for:**

- Replacement of dentures or bridges within 10 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;

Missing Teeth Coverage. Dentures or bridges made to replace permanent, naturally occurring teeth that were missing prior to your coverage effective date are eligible for payment.

Orthodontic Services
(Submission of a treatment plan is suggested before any services are performed)

You are eligible for the following benefits:

- One diagnosis and treatment in lifetime;
- Active treatment including appliances;
- Retention treatment to a maximum of five visits during the period of time specified in the treatment plan.

Payment for orthodontic treatments is made in four installments. The first payment becomes payable when the appliance is installed. Later payments are payable at the end of each six month period. In determining the first installment, Horizon Blue Cross Blue Shield of New Jersey assigns 33% of the charge for the entire course of treatment to the installation of the appliance. The remainder of such charge is prorated over the estimated duration of the orthodontic treatment. These payments are made only for services performed while the person remains insured. If insurance or treatment on a covered person ceases during a period, the amount payable for that period will be prorated.

The group who purchased this policy may have purchased it to replace a plan it had with another insurer/ administrator. If this plan replaces another plan which covered orthodontia, the maximum number of months for which benefits are provided for active or retention treatment will be reduced by the number of months of treatment performed before the effective date of this plan.

***No* benefits will be provided for:**

- Additional orthodontic benefits which are provided within 5 years of the completion of previously eligible treatment:

- Orthodontic treatment beyond the period of time specified in the treatment plan;
- Separate charges for the replacement or repair of any appliance furnished under the treatment plan;
- Any orthodontic procedures instituted before a covered person's effective date of coverage with Horizon Blue Cross Blue Shield of New Jersey or the group's prior carrier as stated above.

Orthodontic benefits are only available for eligible child dependents . No benefits will be provided to an eligible child dependent for Orthodontic services after the last day of the calendar Month in which the eligible child dependent attains age 19.

HOW TO OBTAIN BENEFITS

Pre-Certification

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-Certification 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-Certification.*

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 either the "Maximum Allowable Charge" (MAC) for Participating Dentists, or usual, customary and reasonable ("UCR") allowance for Non Participating Dentists, determined by us, as follows:

100% for Preventive/Diagnostic Services
100% for Therapy/Treatment Services
80% for Oral Surgery Services
80% for Periodontic Services
80% for Onlay and Crown Services
50% for Prosthodontic Services
50% for Orthodontic Services

For any payment percentages shown above that are less than 100%, a Participating Dentist may bill you for the difference up to 100% of MAC. A Participating Dentist must accept 100% of the MAC as payment in full. For Non Participating Dentists, you must pay the difference between Our payment and the Dentist's charge, even if it exceeds the UCR allowance. The UCR payment is based on the 80thPercentileFHRV (Fair Health Relative Value). If your Dentist charges less than the MAC or UCR allowance, We will pay the applicable percentage of the actual charge.

Deductible

The deductible amount is the first **$**25.00 of Covered Dental Expenses per calendar year for each covered family member. However, the total deductible for all covered family members will not exceed $ 75.00 per calendar year. *Deductible does not apply to Preventive/Diagnostic nor Orthodontic Services.*

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 **$**1,000.00 per family during each calendar year, as long as this program is in effect. This maximum is combined for all services excluding Orthodontics.

Orthodontic services will be subject to a separate maximum payment of $ 1,000.00 for covered services during the lifetime of each eligible person.

Periodontic Coverage

Periodontic Services has a benefit period maximum of Unlimited per person per Calendar Year.

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 to restore teeth broken down by excessive decay or trauma. 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;
- Gold foil restorations;
- Services relating to Temporomandibular Joint (TMJ) dysfunction syndrome;
- 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;

- Charges for sterilization fees;

- Charges for missed or broken appointments.

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 primary 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 Horizon Blue Cross Blue Shield of New Jersey, 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 180 days 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 30 days of receipt of the appeal. However, special circumstances, such as delays by you or the dentist in submitting necessary information, may require an extension of this 30-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 covered at least in part by either plan, but in no event will this program's liability as a secondary plan exceed its liability as a primary plan.

SERVICE CENTER

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 6:00 p.m.

For Dental, call:

1-(800)-4DENTAL [1-(800) 433-6825]

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:

_____