NJDPB
Pensions & Benefits
Explore Your Benefits

Employee Dental Plans
Member Guidebook

The Dental Plan Organizations and The Dental Expense Plan
For the State Health Benefits Program and the School Employees' Health Benefits Program

Plan Year
2020

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INTRODUCTION

The State Health Benefits Program (SHBP) was established in 1961. It offers medical, prescription drug, and dental coverage to qualified State and local government public employees, retirees, and eligible dependents. Local employers must adopt a resolution to participate in the SHBP.

The State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the SHBP.

The State Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The School Employees' Health Benefits Program (SEHBP) was established in 2007. It offers medical, prescription drug, and dental coverage to qualified local education public employees, retirees, and eligible dependents. Local education employers must adopt a resolution to participate in the SEHBP.

The School Employees' Health Benefits Commission (SEHBC) is the executive organization responsible for overseeing the SEHBP.

The School Employees' Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.46 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The New Jersey Division of Pensions and Benefits (NJDPB), specifically the Health Benefits Bureau and the Bureau of Policy and Planning, are responsible for the daily administrative activities of the SHBP and the SEHBP.

The Employee Dental Plans consist of the Dental Plan Organizations (DPOs) and the Dental Expense Plan (DEP). The Employee Dental Plans are available to full-time employees of the State of New Jersey, State colleges and universities, certain independent State agencies, and adopting local government and local education employers. Before making any enrollment decision, you should carefully review the standards of eligibility and the conditions, limitations, and exclusions of the benefit coverage offered under each plan. The complete terms of Employee Dental Plans coverage are described in the DPO and DEP contracts with amendments.

Every effort has been made to ensure the accuracy of the *Employee Dental Plans Member Guidebook*. However, State law and the New Jersey Administrative Code govern the SHBP and SEHBP. If there are discrepancies between the information presented in this guidebook and/or plan documents and the law, regulations, or contracts, the law, regulations, and contracts will govern. Furthermore, if you are unsure whether a dental service or procedure is covered, contact your dental plan before you receive services to avoid any denial of coverage issues that could result.

If, after reading this guidebook, you have any questions, comments, or suggestions regarding the information presented, please write to the New Jersey Division of Pensions & Benefits, P.O. Box 295, Trenton, NJ 08625-0295, call us at (609) 292-7524, or send email to: ***pensions.nj@treas.nj.gov***

SECTION ONE

EMPLOYEE DENTAL PLANS ELIGIBILITY

Eligibility for coverage is determined under the provisions of the SHBP. Enrollments, terminations, changes to coverage, etc. must be presented through your employer to the Health Benefits Bureau of the NJDPB. If you have any questions concerning eligibility provisions, you should see your employer's benefits administrator. You can also contact the NJDPB Office of Client Services at (609) 292-7524 or by email at: ***pensions.nj@treas.nj.gov***

State Employees

To be eligible for State Employee coverage, you must work full-time for the State of New Jersey or be an appointed or an elected official of the State of New Jersey (this includes employees of a State agency or authority and employees of a State college or university). For State employees, full-time requires 35 hours per week or more if required by contract or resolution.

State part-time employees covered under P.L. 2003, c. 172 (Chapter 172), and State intermittent employees covered by negotiated agreements between the State of New Jersey and the Communications Workers of America (CWA) are not eligible for coverage under the Employee Dental Plans.

Local Employees

To be eligible for Employee Dental Plans local employer coverage, you must be a full-time employee or an appointed or elected official receiving a salary from a local government/education employer (county, municipality, county or municipal authority, board of education, etc.) that participates in the SHBP or the SEHBP and has adopted a resolution to provide dental benefits under the Employee Dental Plans.

Each participating local employer defines, in its resolution, the minimum hours required to be considered a full-time employee, but it can be no less than 25 hours per week or more if required by contract. Employment must also be for 12 months per year except for employees whose usual work schedule is 10 months per year (the standard school year).

Local part-time employees covered under Chapter 172 are not eligible for coverage under the Employee Dental Plans.

Eligible Dependents

Your eligible dependents are your spouse, civil union partner, or eligible same-sex domestic partner and/or your eligible children. See the NJDPB website for definitions of eligible dependents and required documentation: ***www.nj.gov/treasury/pensions***

Note: There is no provision for dental coverage under P.L. 2005, c. 375 (Chapter 375), which provides medical and/or prescription drug coverage to over age children until age 31.

Retirees

The Employee Dental Plans are not available to retirees. At retirement, retirees who are eligible for enrollment into the Retired Group of the SHBP or SEHBP may elect to enroll for coverage in the Retiree Dental Plans.

Note: Employees who, at retirement, are eligible to enroll in the Retired Group of the SHBP or SEHBP cannot continue Employee Dental Plan coverage under COBRA. See the "COBRA Coverage" section.

For more information about the Retiree Dental Plans, see the *Dental Plans – Retirees* Fact Sheet, or the *Retiree Dental Plans Member Guidebook.* See the "Health Benefits Publications" section.

COBRA COVERAGE

Continuing Coverage When it Would Normally End

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage. COBRA coverage is available for limited time periods, and the member must pay the full cost of the coverage plus an administrative fee.

Under COBRA, you may elect to continue in any or all of the coverages you had as an active employee or dependent (health, prescription drug, dental, and vision). You may also change your health or dental plan when enrolling in COBRA. You may elect to cover the same dependents that you covered while an active employee, or delete dependents from coverage. However, you cannot add dependents who were not covered while an employee, except during the annual Open Enrollment period or unless a qualifying event (marriage, birth or adoption of a child, etc.) occurs within 60 days of the COBRA event.

The rules and plan provisions that govern COBRA coverage for the Employee Dental Plans are the same as those for the SHBP/SEHBP medical plans. Please refer to the *Summary Program Description* for additional information about your rights and responsibilities under COBRA. See the "Health Benefits Publications" section for information on how to obtain this publication.

SECTION TWO

EMPLOYEE DENTAL PLANS

All benefits listed in this guidebook may be subject to limitations and exclusions as described in subsequent sections. Services or supplies not listed in this guidebook may still be eligible under this plan.

GENERAL CONDITIONS OF THE DENTAL PLANS

Enrollment

Enrollment in a dental plan is optional. If you do not enroll when first eligible, you will have the option to enroll each year during the annual SHBP/SEHBP Open Enrollment Period.

In deciding whether to enroll and which plan to choose, you should consider the differences in out-of-pocket costs, the covered services between a Dental Plan Organization (DPO) and the Dental Expense Plan (DEP), and the degree of flexibility that you may want in selecting a dentist.

Eligibility for coverage is determined under the provisions of the SHBP/SEHBP. Enrollments, terminations, changes to coverage, etc. must be presented through your employer to the Health Benefits Bureau of the NJDPB.

Limitation on Changing Dental Plans

If you choose to enroll in a dental plan, you must remain in the dental plan you select for at least 12 months.

Dual Dental Enrollment is Prohibited

SHBP/SEHBP regulations prohibit two members who are married to each other, civil union partners, or eligible same-sex domestic partners, and who are both enrolled in the SHBP or SEHBP, from enrolling under more than one of the dental plans. An individual may belong to a dental plan as an employee or as a dependent but not as both. Furthermore, two SHBP and/or SEHBP members cannot both cover the same children as dependents under their dental plan coverage.

In cases of divorce or single parent coverage of dependents, there is no coordination of benefits under two dental plans. That is, once a claim has been submitted for payment under one plan it is not eligible for additional payment under another dental plan.

Other Enrollment Information

Except as indicated above, the rules for enrollment and information on maintaining coverage in the Employee Dental Plans are the same as those for the SHBP/SEHBP medical plans. Please refer to the *Summary Pro-*

gram Description for additional information about enrollment, dates of coverage, and other coverage provisions under the SHBP and SEHBP.

DENTAL PLAN CHOICES

You may choose to enroll in one of two different types of dental plans:

- The **Dental Plan Organizations (DPOs)** are companies that contract with a network of providers for dental services. There are several DPOs participating in the Employee Dental Plans from which you may choose. You must use providers participating with the DPO you select to receive coverage. Be sure you confirm that the dentist or dental facility you select is taking new patients and participates with the Employee Dental Plans, since DPOs also service other organizations.
- The **Dental Expense Plan (DEP)** is a traditional indemnity plan that allows you to obtain services from any dentist. After you satisfy the $50 annual deductible (the deductible applies to non-preventive services only), you are reimbursed a percentage of the reasonable and customary charges for the services that are covered under the DEP. This plan is administered under a contract between the SHBC and Aetna Life Insurance Company (Aetna).

LEVELS OF COVERAGE

There are four levels of coverage:

- **Single:** covers the employee only;
- **Member and Spouse/Partner:** covers the employee and spouse, civil union partner, or eligible domestic partner;
- **Parent and Child(ren):** covers the employee and all enrolled eligible children; or
- **Family:** covers employee, spouse or partner, and all enrolled eligible children.

DENTAL PLAN PREMIUMS

The cost for participation in a dental plan is shared by the State or local employer and dental plan participants. For a current list of premium rates and payroll deduction schedules, please see your benefits administrator.

State Employees

For State employees paid through the State's Centralized Payroll Unit, premium payments are made through biweekly payroll deductions.

For all other State employees, premium payments are made through a deduction schedule determined by your employer.

State employee premiums can be paid on a pre-tax basis through participation in the Premium Option Plan (POP) of the State's IRC Section 125 Program, Tax$ave. Participation in POP is automatic unless you specifically decline enrollment. See the "Tax$ave" section for more information.

Local Government and Local Education Employees

For local employees, premium payments are made through a deduction schedule determined by your employer.

Note: The State Tax$ave program is not available to local employees. Contact your employer to find out if you are eligible to pay premiums on a pre-tax basis through an IRC Section 125 Program offered by your employer.

EXTENSION OF COVERAGE PROVISIONS

If Eligibility Ends While Undergoing Treatment

If your coverage is terminated voluntarily or due to non-payment of premiums, there is no extension of ongoing treatment for you or your dependents.

Once coverage is terminated for you or any of your dependents, there is no eligibility for continuation of the Employee Dental Plans under the provisions of COBRA. There is also no conversion to an individual policy authorized under this plan.

If you die, and your dependent does not elect to continue Employee Dental Plans coverage under their own account and is undergoing treatment, your dependent's coverage will be extended to cover the following procedures for up to 30 days following the end of their coverage:

- Production of an appliance or modification of an appliance for which the impression was taken while the person was covered;
- Preparation of a crown or restoration for which a tooth was prepared while the person was covered; and
- Root canal therapy for which the pulp chamber was opened while the person was covered.

For Children Over the Age of 26 With Disabilities

In certain circumstances, coverage can be continued for a dependent child over the age of 26. See the NJDPB website at: ***www.nj.gov/treasury/pensions*** for more information about extending coverage for children with disabilities.

Transition of Care

The dental plan shall ensure that all members currently undergoing dental treatment for any condition be transitioned into the new plan without any disruption in coverage or access to providers.

ORTHODONTICS TAKEOVERS FROM PREVIOUS INSURANCE CARRIER

When a member chooses to elect the SHBP/SEHBP Dental Plan, the following items need to occur for orthodontics procedures to be considered eligible under the plan:

- The member must have been covered by an insurance carrier;
- The treatment is only eligible for consideration under the SHBP/SEHBP Plan if the prior carrier covered and considered the member's orthodontic treatment plan;
- The treatment must have started prior to the SHBP/SEHBP Plan effective date;
- The member must provide the new carrier with the banding date, treatment plan, and length of treatment;
- The member must provide the new carrier with the amount the prior carrier paid to date by submitting the necessary documentation;
- Bands need to be placed on the patient's teeth before reaching the plan's specified age limit; and
- Any amounts paid by the prior carrier will be updated to the SHBP/SEHBP orthodontic maximums. The entire amount paid out will be subject to the SHBP/SEHBP plan maximum rather than the prior carrier's maximum.

Note: If the new plan does not cover orthodontia, no benefits will be paid.

SPECIAL PROVISIONS OF THE EMPLOYEE DENTAL PLANS

Coordination of Benefits With Other Insurance Plans

There is no coordination of benefits between two SHBP/SEHBP dental plans because no individual is eligible for coverage in more than one dental plan.

If you and your dependents are also covered for dental expenses by other plans, certain rules apply that determine which plan provides the primary coverage and how much each plan will reimburse you. The purpose of these rules is to prevent a combined reimbursement from both plans that exceeds the expenses that you actually incur. Although there may be special cases not described here, the usual determination of which plan provides primary coverage is as follows:

- The employee's primary dental coverage is provided by the DEP or the DPO;
- If your spouse/partner is enrolled as your dependent and is also covered by a dental plan through his or her employer, your spouse/partner's primary coverage is through the dental plan offered by his or her employer;
- If your children are enrolled as dependents in your plan and your spouse/partner's plan, their primary coverage is provided by the dental plan of the parent whose birthday falls earlier in the year. If your spouse/partner's plan does not follow this rule, then the rule in the other program will determine the order of benefits; or
- In the case of a separation, divorce, dissolution of a civil union or domestic partnership, or parents who are not married, the primary coverage for a child is provided in this order: by the plan of the parent who is legally responsible for the dental expenses of the child; by the plan of the parent with custody of the child; by the plan of the spouse/partner of the parent with custody of the child; or by the plan of the non-custodial parent.

THIRD PARTY LIABILITY

Repayment Agreement

If you have received benefits from your dental plan for services that are related to either an automobile accident or your work, the Employee Dental Plans have the right to recover those payments. This means that if your dental expenses are also reimbursed by a third party through a settlement, satisfied by a judgment, or other means, you are required to return any benefits paid for illness or injury to the Employee Dental Plans. The repayment will only be equal to the amount paid by the Employee Dental Plans.

This provision is binding whether the payment received from the third party is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, whether or not the third party has admitted liability for the payment.

Recovery Right

You are required to cooperate with the Employee Dental Plans in recovering any benefits paid by the plan that may also be payable by a third party. The Employee Dental Plans may:

- Assume your right to receive payment for benefits from the third party;
- Require you to provide all information and sign and return all documents necessary to exercise the Employee Dental Plans' rights under this provision, before any benefits are provided under your group's policy; or
- Require you to give testimony, answer interrogatories, attend depositions, and comply with all legal actions which the Employee Dental Plans may find necessary to recover money from all sources when a third party may be responsible for damages or injuries.

HIPAA PRIVACY

The SHBP and SEHBP make every effort to safeguard the health information of their members and comply with the privacy provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA requires medical and dental plans to maintain the privacy of any personal information relating to its members' physical or mental health. the "Notice of Privacy Practices" section for further information.

AUDIT OF DEPENDENT COVERAGE

Periodically the NJDPB performs an audit using a random sample of members to determine if enrolled dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union, birth certificates, or tax returns are required and coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of all coverage and may include financial restitution for claims paid. Members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law.

HEALTH CARE FRAUD

Health care fraud is an intentional deception or misrepresentation that results in an unauthorized benefit to a member or to some other person. Any individual who willfully and knowingly engages in an activity intended to defraud the SHBP or SEHBP will face disciplinary action that could include termination of employment and may result in prosecution. Any member who receives monies fraudulently from a health plan will be required to fully reimburse the plan.

SECTION THREE

THE DENTAL PLAN ORGANIZATIONS

A Dental Plan Organization (DPO) is similar to a medical Health Maintenance Organization (HMO) program. The full cost for most services is prepaid to your dentist, but certain services require an additional copayment from you. Also, if you choose a more expensive treatment than deemed appropriate by your dental provider, you must pay the extra cost. Further, you will not be covered for services if you go to a dentist who is not a member of your DPO, unless you are referred by your DPO dentist. There are several DPOs included among the Employee Dental Plans. Among these organizations, there are two types of plans – Dental Center and Individual Practice Associations (IPA).

- **Dental Centers** employ a group of dentists and technicians who are located at a central office. In a Dental Center Plan, you do not have the option to select a particular dentist unless permitted by the Dental Center. However, some DPOs offer both a Dental Center and a list of participating dentists, thereby giving you the option of selecting a center or a particular dentist.
- **Individual Practice Associations** (IPA) consist of a network of participating dentists who work in their own offices. If you choose an IPA, you must select a specific dentist in the IPA who will treat you and your dependents.

The DPO dentist is responsible for providing all of the services that are listed as covered in this guidebook. If the participating dentist that you have selected does not provide a specific service, then the DPO must refer you to another participating dentist located within 10 miles of your dentist's office (or 20 miles for orthodontic service). If you agree, the DPO may also refer you to a dentist located beyond these limits.

If the DPO has no participating dentist who can provide the service in your geographical area, the DPO must refer you to a nonparticipating dentist within the 10- or 20-mile limit. If there is no dentist within this area, you must be referred to the dentist closest to your dentist's office.

If the DPO dentist refers you to another dentist and that referral is approved by the DPO, you will have the same coverage for the service as if you had been treated by your dentist. However, if you select an outside dentist on your own, the service will not be covered.

CONSIDERATIONS IN CHOOSING A DPO

- Obtain information about the DPOs and participating dentists from your benefits administrator or the NJDPB website. If you choose a dentist rather than a Dental Center, check with the DPO and the dentist to be sure that the dentist: is a member of the DPO; services members of the Employee Dental Plans; and will accept you as a new patient.
- If you choose a dentist, you should check with the dentist to make sure that he or she plans to stay in the DPO. If the dentist leaves, you will have to select another dentist who participates with that DPO.
- You should check to determine that the DPO dentist or center can serve the needs of your entire family and whether the days and hours of operation are convenient for you and your family.
- If your dentist leaves the DPO, and there are no other dentists in the DPO within 30 miles of your home, you may switch to another dental plan (either another DPO or the DEP).

COVERED SERVICES

The following is a list of covered services and, if applicable, required copayments. Copayments are your portion of the cost for the service.

Codes	Description of Covered Services	Copayments
D0100-D0999 I. Diagnostic		
Clinical Oral Evaluations *Oral evaluations are limited to two in a calendar year. Emergency or limited oral evaluations are covered, limited to one evaluation per patient, per dentist, per calendar year. There are no copayments for diagnostic services.*		
D0120	Periodic Oral Evaluation	$0
D0140	Limited Oral Evaluation — Problem Focused	$0
D0145	Oral Evaluation for Patient Under Three Years of Age and Counseling With Primary Caregiver	$0
D0150	Comprehensive Oral Evaluation — New or Established Patient	$0
D0160	Detailed and Extensive Oral Evaluation — Problem Focused, by Report	$0
Radiographs *Bitewing X-rays are limited to two series of up to four films in a calendar year; set of full mouth X-rays are limited to once per 36 month interval; no more than 18 films per set of mouth X-rays.*		
D0210	Intraoral — Complete Series of Radiographic Images	$0
D0220	Intraoral — Periapical — First Radiographic Image	$0
D0230	Intraoral — Peripical — Each Additional Radiographic Image	$0
D0240	Intraoral — Occlusal Radiographic Image	$0
D0250	Extraoral — 2D Projection Radiographic Image created using a Stationary Radiation Source, and Detector	$0
D0251	Extraoral — Posterior Dental Radiographic Image	$0
D0270	Bitewings — Single Radiographic Image	$0
D0272	Bitewings — Two Radiographic Images	$0
D0273	Bitewings — Three Radiographic Images	$0
D0274	Bitewings — Four Radiographic Images	$0
D0277	Vertical Bitewings — Seven to Eight Radiographic Images	$0
D0330	Panoramic Radiographic Image	$0
D0340	2D Cephalometric Radiographic Image — Acquisition, Measurement and Analysis	$0
D0391	Interpretation of Diagnostic Image by a Practitioner Not Associated With the Capture of the Image, Including Report	$0
Test and Laboratory Examinations		
D0414	Laboratory Processing of Microbial Specimen to Include Culture and Sensitivity Studies, and Preparation and Transmission of Written Report	$0
D0415	Collection of Microorganisms for Culture and Sensitivity	$0
D0416	Viral Culture	$0
D0425	Caries Susceptibility Tests	$0
D0460	Pulp Vitality Tests	$0
D0470	Diagnostic Casts	$0
D0600	Non-ionizing Diagnostic Procedure Capable of Quantifying, Monitoring, and Recording Changes in Structure of Enamel, Dentin, and Cementum	$0
D1000-D1999 II. Preventive		
Dental Prophylaxis *Limited to two in a calendar year*		
D1110	Prophylaxis — Adult	$0
D1120	Prophylaxis — Child	$0
Topical Fluoride Treatment (Office Procedure) *Limited to two in a calendar year, and only for eligible dependent children under the age of 19 years.*		
D1206	Topical Application of Fluoride Varnish	$0
D1208	Topical Application of Fluoride	$0
Other Preventive Services *Sealants are limited to once per lifetime for permanent molars of eligible dependent children under the age of 19 years.*		
D1330	Oral Hygiene Instruction	$0
D1351	Sealant — Per Tooth	$0
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth	$0
D1353	Sealant Repair — Per Tooth	$0
D1354	Interim Caries Arresting Medicament Application	$0
Space Maintenance (Passive Appliances)		
D1510	Space Maintainer — Fixed — Unilateral Excludes a Distal Shoe Space Maintainer - Per Quadrant	$0
D1515	Space Maintainer — Fixed — Bilateral	$0

Codes	Description of Covered Services	Copayments
D1520	Space Maintainer — Removable — Unilateral - Per Quadrant	$0
D1525	Space Maintainer — Removable — Bilateral	$0
D1551	Re-Cement or Re-Bond Bilateral Space Maintainer - Maxillary	$0
D1552	Re-Cement or Re-Bond Bilateral Space Maintainer - Mandibular	$0
D1553	Re-Cement or Re-Bond Bilateral Space Maintainer - Per Quadrant	$0
D1556	Removal of Fixed Unilateral Space Maintainer - Per Quadrant	$0
D1557	Removal of Fixed Unilateral Space Maintainer - Maxillary	$0
D1558	Removal of Fixed Unilateral Space Maintainer - Mandibular	$0
D1575	Distal Shoe Space Maintainer — Fixed — Unilateral - Per Quadrant	$0
D2000-D2999 III. Restorative		
The replacement of a crown is covered only after a five-year period measured from the date on which the crown was previously placed.		
Amalgam Restorations (Including Polishing)		
D2140	Amalgam — One Surface — Primary or Permanent	$0
D2150	Amalgam — Two Surfaces — Primary or Permanent	$0
D2160	Amalgam — Three Surfaces — Primary or Permanent	$0
D2161	Amalgam — Four or More Surfaces — Primary or Permanent	$0
Resin Restorations		
D2330	Resin-Based Composite — One Surface — Anterior	$0
D2331	Resin-Based Composite — Two Surfaces — Anterior	$0
D2332	Resin-Based Composite — Three Surfaces — Anterior	$0
D2335	Resin-Based Composite — Four or More Surfaces or Involving Incisal Angle — Anterior	$0
D2390	Resin-Based Composite Crown — Anterior	$35
D2391	Resin-Based Composite — One Surface — Posterior	$15
D2392	Resin-Based Composite — Two Surfaces — Posterior	$25
D2393	Resin-Based Composite — Three Surfaces — Posterior	$35
D2394	Resin-Based Composite — Four or More Surfaces — Posterior	$45
Inlay/Onlay Restorations		
D2510	Inlay — Metallic — One Surface	$100
D2520	Inlay — Metallic — Two Surfaces	$100
D2530	Inlay — Metallic — Three or More Surfaces	$100
D2542	Onlay — Metallic — Two Surfaces	$100
D2543	Onlay — Metallic — Three Surfaces	$100
D2544	Onlay — Metallic — Four or More Surfaces	$100
D2610	Inlay — Porcelain/Ceramic — One Surface	$115
D2620	Inlay — Porcelain/Ceramic — Two Surfaces	$115
D2630	Inlay — Porcelain/Ceramic — Three or More Surfaces	$115
D2642	Onlay — Porcelain/Ceramic — Two Surfaces	$115
D2643	Onlay — Porcelain/Ceramic — Three Surfaces	$115
D2644	Onlay — Porcelain/Ceramic — Four or More Surfaces	$115
D2650	Inlay — Resin-Based Composite — One Surface	$115
D2651	Inlay — Resin-Based Composite — Two Surfaces	$115
D2652	Inlay — Resin-Based Composite — Three or More Surfaces	$115
D2662	Onlay — Resin-Based Composite — Two Surfaces	$115
D2663	Onlay — Resin-Based Composite — Three Surfaces	$115
D2664	Onlay — Resin-Based Composite — Four or More Surfaces	$115
Crowns — Single Restorations Only		
D2710	Crown — Resin-Based Composite (Indirect) (See **Note**)	$115
D2720	Crown — Resin With High Noble Metal	$150
D2721	Crown — Resin With Predominantly Base Metal	$150
D2722	Crown — Resin With Noble Metal	$150
D2740	Crown — Porcelain/Ceramic Substrate	$200
D2750	Crown — Porcelain Fused to High Noble Metal	$225

Codes	Description of Covered Services	Copayments
D2751	Crown — Porcelain Fused to Predominantly Base Metal	$200
D2752	Crown — Porcelain Fused to Noble Metal	$200
D2753	Crown - Porcelain Fused to Titanium and Titanium Alloys	$200
D2780	Crown — 3/4 Cast High Noble Metal	$225
D2781	Crown — 3/4 Cast Predominantly Base Metal	$200
D2790	Crown — Full Cast High Noble Metal	$225
D2791	Crown — Full Cast Predominantly Base Metal	$200
D2792	Crown — Full Cast Noble Metal	$200
D2794	Crown — Titanium and Titanium Alloys	$225
Note: There is no copayment for procedure D2710 when performed in conjunction with a permanent crown on the same tooth.		

Codes	Description of Covered Services	Copayments
Other Restorative Services		
D2910	Recement Inlay, Onlay, or Partial Coverage Restoration	$0
D2915	Recement Cast or Prefabricated Post and Core	$0
D2920	Recement Crown	$0
D2921	Reattachment of Tooth Fragment Incisal Edge or Cusp	$0
D2929	Prefabricated Porcelain/ Ceramic Crown — Primary Tooth	$49
D2930	Prefabricated Stainless Steel Crown — Primary Tooth	$35
D2931	Prefabricated Stainless Steel Crown — Permanent Tooth	$35
D2932	Prefabricated Resin Crown	$35
D2933	Prefabricated Stainless Steel Crown With Resin Window	$35
D2934	Prefabricated Esthetic Coated Stainless Steel Crown — Primary Tooth	$35
D2940	Protective Restoration	$0
D2941	Interim Therapeutic Restoration — Primary Dentition	$0
D2950	Core Buildup, Including any Pins	$0
D2951	Pin Retention — Per Tooth in Addition to Restoration	$0
D2952	Cast Post and Core in Addition to Crown	$40
D2954	Prefabricated Post and Core in Addition to Crown	$40
D2955	Post Removal	$0
D2971	Additional Procedures to Construct New Crown under Existing Partial Denture Framework	$0

Codes	Description of Covered Services	Copayments
D2980	Crown Repair Necessitated by Restorative Material Failure	$0
D2981	Inlay Repair Necessitated by Restorative Material Failure	$0
D2982	Onlay Repair Necessitated by Restorative Material Failure	$0
D2983	Veneer Repair Necessitated by Restorative Material Failure	$0
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	$0
D3000-D3999 IV. Endodontics		
Pulp Capping		
D3110	Pulp Capping — Direct — Excluding Final Restoration	$0
D3120	Pulp Capping — Indirect — Excluding Final Restoration	$0
Pulpotomy		
D3220	Therapeutic Pulpotomy — Excluding Final Restoration	$25
D3222	Partial Pulpotomy for Apexogenesis — Permanent Tooth With Incomplete Root Development	$25
Endodontic Therapy on Primary Teeth		
D3230	Pulpal Therapy (Resorbable Filling) — Anterior-Primary Tooth — Excluding Final Restoration	$20
D3240	Pulpal Therapy (Resorbable Filling) — Posterior-Primary Tooth — Excluding Final Restoration	$20
Endodontic Therapy		
D3310	Anterior (Excluding Final Restoration)	$100
D3320	Bicuspid (Excluding Final Restoration)	$125

Codes	Description of Covered Services	Copayments
D3330	Molar (Excluding Final Restoration)	$150
Endodontic Retreatment		
D3346	Retreatment of Previous Root Canal Therapy — Anterior	$125
D3347	Retreatment of Previous Root Canal Therapy — Bicuspid	$150
D3348	Retreatment of Previous Root Canal Therapy — Molar	$175
Apexification/Recalcification Procedures		
D3351	Apexification/Recalcification — Initial Visit	$35
D3352	Apexification/Recalcification — Interim Medication Replacement	$35
D3353	Apexification/Recalcification — Final Visit	$35
Apicoectomy/Periapical Services		
D3410	Apicoectomy/Periradicular Surgical — Anterior	$90
D3421	Apicoectomy/Periradicular Surgical — Bicuspid First Root	$90
D3425	Apicoectomy/Periradicular Surgical — Molar First Root	$90
D3426	Apicoectomy/Periradicular Surgical — Each Additional Root	$40
D3427	Periradicular Surgical — Without Apicoectomy	$90
D3430	Retrograde Filling — Per Root	$20
D3450	Root Amputation — Per Root	$40
Other Endodontic Procedures		
D3910	Surgical Procedure for Isolation of Tooth With Rubber Dam	$0
D3920	Hemisection (Including any Root Removal) — Not Including Root Canal Therapy	$60

Codes	Description of Covered Services	Copayments
D4000-D4999 V. Periodontics		
Coverage for surgical periodontal procedures, excluding scaling and root planing, is limited to one surgical periodontal treatment per quadrant every 36 months; coverage for scaling and root planing is limited to one nonsurgical periodontal treatment per quadrant every 12 months.		
Surgical Services		
D4210	Gingivectomy or Gingivoplasty — Four or more Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$85
D4211	Gingivectomy or Gingivoplasty — One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$30
D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure — Per Tooth	$12
D4240	Gingival Flap Procedure Including Root Planing — Four or more Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$90
D4241	Gingival Flap Procedure including Root Planing — One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$60
D4245	Apically Positioned Flap	$90
D4249	Clinical Crown Lengthening — Hard Tissue	$90
D4260	Osseous Surgery (Including Flap Entry and Closure) — Four or more Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$175
D4261	Osseous Surgery (Including Flap Entry and Closure) — One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$100

Codes	Description of Covered Services	Copayments
D4263	Bone Replacement Graft — Retained Natural Tooth — First Site in Quadrant Site	$100
D4264	Bone Replacement Graft — Retained Natural Tooth — Each Additional Site in Quadrant	$50
D4266	Guided Tissue Regeneration — Resorbable Barrier per Site	$90
D4267	Guided Tissue Regeneration — Non-resorbable Barrier per Site (Includes Membrane Removal)	$90
D4270	Pedicle Soft Tissue Graft Procedure	$175
D4273	Autogenous Connective Tissue Graft Procedures (Including Donor and Recipient Surgical Sites) — First Tooth, Implant, or Edentulous Tooth Position in Graft	$175
D4274	Mesial/Distal Procedure — Single Tooth (When not Performed in Conjunction With Surgical Procedures in the same Anatomical Area)	$40
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site and Donor Material) — First Tooth, Implant, or Edentulous Tooth Position in Graft	$175
D4276	Combined Connective Tissue and Double Pedicle Graft — Per Tooth	$175
D4277	Free Soft Tissue Graft Procedure (Including Recipient and Donor Surgical Sites) — First Tooth, Implant, or Edentulous Tooth Position in a Graft	$70

Codes	Description of Covered Services	Copayments
D4278	Free Soft Tissue Graft Procedure (Including Recipient and Donor Surgical Sites) — Each additional Contiguous Tooth, Implant, or Edentulous Tooth Position in same Graft Site	$35
D4283	Autogenous Connective Tissue Graft Procedure (Including Donor and Recipient Surgical Sites) — Each additional Contiguous Tooth, Implant, or Edentulous Tooth Position in same Graft Site	$96
D4285	Non-Autogenous Connective Tissue Graft Procedure (Including Recipient Surgical Site and Donor Material) — Each Additional Contiguous Tooth, Implant, or Edentulous Tooth Position in same Graft Site	$96
Non-Surgical Periodontal Services		
D4320	Provisional Splinting — Intracoronal	$0
D4321	Provisional Splinting — Extracoronal	$0
D4341	Periodontal Scaling and Root Planing — Four or More Teeth per Quadrant	$55
D4342	Periodontal Scaling or Root Planing — One to Three Teeth per Quadrant	$40
D4346	Scaling in Presence of Generalized Moderate or Severe Gingival Inflammation — Full Mouth, after Oral Evaluation	$28
D4355	Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis	$55

Codes	Description of Covered Services	Copayments
Other Periodontal Services		
D4910	Periodontal Maintenance	$30
D4920	Unscheduled Dressing Change (By someone other than Treating Dentist)	$0
D5000-D5999 VI. Prosthodontics (Removable)		
The replacement of an existing removable prosthetic appliance is covered only after a five-year period measured from the date on which the appliance was previously placed.		
Complete Dentures *Including Routine Post Delivery Care*		
D5110	Complete Denture — Maxillary	$250
D5120	Complete Denture — Mandibular	$250
D5130	Immediate Denture — Maxillary	$275
D5140	Immediate Denture — Mandibular	$275
Partial Dentures *Including Routine Post Delivery Care*		
D5211	Maxillary Partial Denture — Resin Base (Including any Conventional Clasps, Rests, and Teeth)	$250
D5212	Mandibular Partial Denture — Resin Base (Including any Conventional Clasps, Rests, and Teeth)	$250
D5213	Maxillary Partial Denture — Cast Metal Framework w/ Resin Denture Bases (Including Retentive/Clasping Materials,)	$275
D5214	Mandibular Partial Denture — Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials)	$275

Codes	Description of Covered Services	Copayments
D5221	Immediate Maxillary Partial Denture — Resin Base (Including Retentive/Clasping Materials)	$288
D5222	Immediate Mandibular Partial Denture — Resin Base (Including Retentive/Clasping Materials)	$288
D5223	Immediate Maxillary Partial Denture — Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests, and Teeth) Includes limited Follow-up Care Only; Does not Include Future Rebasing	$316
D5224	Immediate Mandibular Partial Denture — Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests, and Teeth)	$316
D5225	Maxillary Partial Denture — Flexible Base (Including any Clasps, Rests, and Teeth)	$300
D5226	Mandibular Partial Denture — Flexible Base (Including any Clasps, Rests, and Teeth)	$300
D5281	Removable Unilateral Partial Denture — One Piece Cast Metal (Including Clasps and Teeth)	$125
D5284	Removable Unilateral Partial Denture - One Piece Flexible Base (Including Clasps and teeth) - Per Quadrant	$150
D5286	Removable Unilateral Partial Denture - One Piece Resin (Including Clasps and teeth) - Per Quadrant	$125

Codes	Description of Covered Services	Copayments
Adjustments to Removable Prostheses		
D5410	Adjust Complete Denture — Maxillary	$0
D5411	Adjust Complete Denture — Mandibular	$0
D5421	Adjust Partial Denture — Maxillary	$0
D5422	Adjust Partial Denture — Mandibular	$0
Repairs to Complete Dentures		
D5510	Repair Broken Complete Denture Base	$35
D5520	Replace Missing or Broken Teeth — Complete Denture — Each Tooth	$35
Repairs to Partial Dentures		
D5610	Repair Resin Denture Base	$35
D5620	Repair Cast Framework	$35
D5630	Repair or Replace Broken Clasp — Per Tooth	$35
D5640	Replace Broken Teeth — Per Tooth	$35
D5650	Add Tooth to Existing Partial Denture	$35
D5660	Add Clasp to Existing Partial Denture — Per Tooth	$35
Denture Rebase Procedures		
D5710	Rebase Complete Maxillary Denture	$85
D5711	Rebase Complete Mandibular Denture	$85
D5720	Rebase Maxillary Partial Denture	$85
D5721	Rebase Mandibular Partial Denture	$85

Codes	Description of Covered Services	Copayments
Denture Reline Procedures		
D5730	Reline Complete Maxillary Denture — Chairside	$40
D5731	Reline Complete Mandibular Denture — Chairside	$40
D5740	Reline Maxillary Partial Denture — Chairside	$40
D5741	Reline Mandibular Partial Denture — Chairside	$40
D5750	Reline Complete Maxillary Denture — (Lab Process)	$40
D5751	Reline Complete Mandibular Denture — (Lab Process)	$40
D5760	Reline Maxillary Partial Denture — (Lab Process)	$40
D5761	Reline Mandibular Partial Denture — (Lab Process)	$40
Other Removable Prosthetic Services		
D5810	Interim Complete Denture (Maxillary)	$40
D5811	Interim Complete Denture (Mandibular)	$40
D5820	Interim Partial Denture (Maxillary)	$40
D5821	Interim Partial Denture (Mandibular)	$40
D5850	Tissue Conditioning (Maxillary)	$40
D5851	Tissue Conditioning (Mandibular)	$40
D6200-D6999 IX. Prosthodontics, Fixed		
Fixed Partial Denture Pontics		

Codes	Description of Covered Services	Copayments
D6097	Abutment Supported Crown - Porcelain Fused to Titanium and Titanium Alloys	$200
D6210	Pontic — Cast High Noble Metal	$225
D6211	Pontic — Cast Predominantly Base Metal	$200
D6212	Pontic — Cast Noble Metal	$200
D6214	Pontic — Titanium	$225
D6240	Pontic — Porcelain Fused to High Noble Metal	$225
D6241	Pontic — Porcelain Fused to Predominantly Base Metal	$200
D6242	Pontic — Porcelain Fused to Noble Metal	$200
D6243	Pontic - Porcelain Fused to Titanium and Titanium Alloys	$200
D6245	Pontic — Porcelain/Ceramic	$200
D6250	Pontic — Resin With High Noble Metal	$150
D6251	Pontic — Resin With Predominantly Base Metal	$150
D6252	Pontic — Resin With Noble Metal	$150
Fixed Partial Denture Retainers — Inlays/Onlays		
D6545	Retainer — Cast Metal for Resin Bonded Fixed Prosthesis	$100
D6549	Resin Retainer — For Resin Bonded Fixed Prosthesis	$75
D6602	Inlay — Cast High Noble Metal — Two Surfaces	$75
D6603	Inlay — Cast High Noble Metal — Three or More Surfaces	$175
D6604	Inlay — Cast Predominantly Base Metal — Two Surfaces	$100

Codes	Description of Covered Services	Copayments
D6605	Inlay — Cast Predominantly Base Metal — Three or More Surfaces	$100
D6606	Inlay — Cast Noble Metal — Two Surfaces	$155
D6607	Retainer Inlay — Cast Noble Metal — Three or More Surfaces	$155
D6610	Retainer Onlay — Cast High Noble Metal — Two Surfaces	$185
D6611	Retainer Onlay — Cast High Noble Metal — Three or More Surfaces	$185
D6612	Retainer Onlay — Cast Predominantly Base Metal — Two Surfaces	$100
D6613	Retainer Onlay — Cast Predominantly Base Metal — Three or More Surfaces	$100
D6614	Retainer Onlay — Cast Noble Metal — Two Surfaces	$175
D6615	Retainer Onlay — Cast Noble Metal — Three or More Surfaces	$175
D6624	Retainer Inlay — Titanium	$175
D6634	Retainer Onlay — Titanium	$185
Fixed Partial Denture Retainers — Crown		
D6720	Retainer Crown — Resin With High Noble Metal	$150
D6721	Retainer Crown — Resin With Predominantly Base Metal	$150
D6722	Retainer Crown — Resin With Noble Metal	$150
D6740	Retainer Crown — Porcelain/ Ceramic	$200
D6750	Retainer Crown — Porcelain Fused to High Noble Metal	$225

Codes	Description of Covered Services	Copayments
D6751	Retainer Crown — Porcelain Fused to Predominantly Base Metal	$200
D6752	Retainer Crown — Porcelain Fused to Noble Metal	$200
D6753	Retainer Crown - Porcelain Fused to Titanium and Titanium Alloys	$200
D6780	Retainer Crown — 3/4 Cast High Noble Metal	$225
D6781	Retainer Crown — 3/4 Cast Predominantly Base Metal	$200
D6782	Retainer Crown — 3/4 Cast Noble Metal	$200
D6783	Retainer Crown — 3/4 Porcelain/Ceramic	$200
D6784	Retainer Crown 3/4- Titanium and Titanium Alloys	$200
D6790	Retainer Crown — Full Cast High Noble Metal	$225
D6791	Retainer Crown — Full Cast Predominantly Base Metal	$200
D6792	Retainer Crown — Full Cast Noble Metal	$200
D6794	Retainer Crown — Titanium	$225
Other Fixed Partial Denture Services		
D6930	Recement Fixed Partial Denture	$15
D6980	Fixed Partial Denture Repair Necessitated by Restorative Material Failure	$25
D7000-D7999 X. Oral and Maxillofacial Surgery		
Extractions *Includes local anesthesia, suturing, if needed, and routine post-operative care.*		

Codes	Description of Covered Services	Copayments
D7111	Extraction — Coronal Remnants — Deciduous Tooth	$10
D7140	Extraction — Erupted Tooth or Exposed Root (Elevation and/ or Forceps Removal) Includes Removal of Tooth Structure, Minor Smoothing of Socket Bone, and Closure, as Necessary	$20
Surgical Extractions *Includes local anesthesia, suturing, if needed, and routine post-operative care.*		
D7210	Extraction — Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth, and Including Elevation of Mucoperiosteal Flap if Indicated	$30
D7220	Removal of Impacted Tooth — Soft Tissue	$55
D7230	Removal of Impacted Tooth — Partially Bony	$55
D7240	Removal of Impacted Tooth — Completely Bony	$65
D7241	Removal of Impacted Tooth — Completely Bony With Complications	$65
D7250	Removal of Residual Tooth Roots — Cutting Procedure	$30
D7251	Coronectomy — Intentional Partial Tooth Removal	$33
Other Surgical Procedures		
D7260	Oroantral Fistula Closure	$100
D7261	Primary Closure of a Sinus Perforation	$100
D7270	Tooth Reimplantation/ Stabilization	$60

Codes	Description of Covered Services	Copayments
D7280	Exposure of an Unerupted Tooth	$60
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$60
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$0
D7285	Biopsy of Oral Tissue — Hard (Bone, Tooth)	$60
D7286	Biopsy of Oral Tissue — Soft	$25
D7287	Exfoliative Cytology — Sample Collection	$13
D7291	Transseptal Fiberotomy Supra Crestal Fiberotomy — By Report	$20

Codes	Description of Covered Services	Copayments
Alveoloplasty — Surgical Preparation of the Ridge for Dentures		
D7310	Alveoloplasty in Conjunction With Extractions — Four or More Teeth or Tooth Spaces, per Quadrant. The Alveoloplasty is Distinct (Separate Procedure) from Extractions. Usually in Preparation for a Prosthesis or Other Treatments Such as Radiation Therapy and Transplant Surgery	$30
D7311	Alveoloplasty in Conjunction With Extractions — One to Three Teeth or Tooth Spaces, per Quadrant. The Alveoloplasty is Distinct (Separate Procedure) from Extractions. Usually in Preparation for a Prosthesis or Other Treatments Such as Radiation Therapy and Transplant Surgery	$15
D7320	Alveoloplasty **not** in Conjunction With Extractions — Per Quadrant	$35
D7321	Alveoloplasty **not** in Conjunction With Extractions — One to Three Teeth or Tooth Spaces per Quadrant	$20
Removal of Cysts, Tumors, and Neoplasms		
D7450	Removal of Benign Odontogenic Cyst or Tumor — Lesion up to 1.25 cm Diameter	$60
D7451	Removal of Benign Odontogenic Cyst or Tumor — Lesion Greater than 1.25 cm Diameter	$60

Codes	Description of Covered Services	Copayments
D7460	Removal of Benign Non-Odontogenic Cyst or Tumor — Lesion up to 1.25 cm Diameter	$60
D7461	Removal of Benign Non-Odontogenic Cyst or Tumor — Lesion Greater than 1.25 cm Diameter	$60
Excision of Bone Tissue		
D7471	Removal of Lateral Exostosis — Maxilla or Mandible	$90
D7472	Removal Torus Palatinus	$90
D7473	Removal Torus Mandibularis	$90
D7485	Reduction of Osseous Tuberosity	$90
Surgical Incision		
D7510	Incision and Drainage of Abscess — Intraoral — Soft Tissue	$25
D7511	Incision and Drainage of Abscess — Intraoral — Soft Tissue — Complicated (Includes Drainage of Multiple Facial Spaces)	$30
D7520	Incision and Drainage of Abscess — Extraoral — Soft Tissue	$35
D7521	Incision and Drainage of Abscess — Extraoral — Soft Tissue — Complicated (Includes Drainage of Multiple Facial Spaces)	$40
Other Repair Procedures		
D7922	Placement of Intra-Socket Bilolgical Dressing to Aid In Hemostasis or Clot Stabilization, Per Site	$0
D7953	Bone Replacement Graft for Ridge Preservation — Per Site	$75

Codes	Description of Covered Services	Copayments
D7960	Frenulectomy — Also Known as Frenectomy or Frenotomy — Separate Procedure not Incidental to Another Procedure. Removal or Release of Mucosal and Muscle Elements of a Buccal, Labial, or Lingual Frenum that is Associated with a Pathological Condition, or Interferes with Proper Oral Development or Treatment	$60
D7963	Frenuloplasty	$65
D7970	Excision of Hyperplastic Tissue — Per Arch	$60
D7971	Excision of Pericoronal Gingiva Removal of Inflammatory or Hypertrophied Tissues Surrounding Partially Erupted/ Impacted Teeth	$30
D7972	Surgical Reduction of Fibrous Tuberosity	$60
Miscellaneous Services		
D9110	Palliative (Emergency) Treatment of Dental Pain — Minor Procedure	$0
D9211	Regional Block Anesthesia	$0
D9212	Trigeminal Division Block Anesthesia	$0
D9215	Local Anesthesia	$0
D9219	Evaluation for Deep Sedation or General Anesthesia	$0
D9223	Deep Sedation/General Anesthesia — Each 15-Minute Increment	$20
D9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	$0
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia — Each 15-Minute Increment	$20

Codes	Description of Covered Services	Copayments
D9310	Consultation (Diagnostic Service Provided by a Dentist or Physician other than Practitioner Providing Treatment)	$0
D9311	Treating Dentist Consults with a Medical Health Care Professional Concerning Medical Issues that May Affect Patient's Planned Dental Treatment	$0
D9430	Office Visit Observation	$0
D9440	Office Visit After Hours	$0
D9610	Therapeutic Drug Injection — By Report	$0
D9612	Therapeutic Paternal Drug, Two or more Administrations Different Medications	$0
D9630	Drugs or Medicaments Dispensed in the Office for Home Use	$0
D9910	Application of Desensitizing Medication	$0
D9930	Treat Complications — By Report	$0
D9932	Cleaning and Inspection of Removable Complete Denture, Maxillary	$0
D9933	Cleaning and Inspection of Removable Complete Denture, Mandibular	$0
D9934	Cleaning and Inspection of Removable Partial Denture, Maxillary	$0
D9935	Cleaning and Inspection of Removable Partial Denture, Mandibular	$0
D9940	Occlusal Guard — By Report	$40

Codes	Description of Covered Services	Copayments
D9942	Repair and/or Reline of Occlusal Guard	$20
D9943	Occlusal Guard Adjustment	$5
D9951	Occlusal Adjustment — Limited	$0
D9952	Occlusal Adjustment — Complete	$60
D9997	Dental Case Management - Patients With Special Health Care Needs	$0

Orthodontics

Treatment plan maximum of 24 months.

1. Patient under 18 years of age at the start of treatment — Class I, II, and III malocclusion (copayment required of $1,000 or 50 percent of reasonable and customary charges, whichever is less).
2. Patient 18 years of age or over at the start of treatment — Class I, II, and III malocclusion (copayment required of $1,750 or 50 percent of reasonable and customary charges, whichever is less). Includes Invisalign as an optional treatment procedure — this procedure may fall under the "More Expensive Services" option and as such, the member choosing this option would be responsible for the difference between Invisalign charges and the standard adult orthodontic charge.

More Expensive Services

A covered individual may elect a more expensive procedure than an appropriate procedure recommended by the dentist. The covered individual shall pay any copayment required for the less expensive procedure, plus the difference in cost between the two procedures, on the basis of the reasonable and customary dental charges for the procedures.

Emergency Services — Out-of-Area

Emergency Treatment is defined as when a covered SHBP (or SEHBP) member or dependent is at least 50 miles from home, any necessary service or procedure which is rendered as the direct result of an unforeseen occurrence and requires immediate, urgent action or remedy. Examples are: acute pain, bleeding, fractured tooth, broken filling, broken front tooth, broken denture, and lost or loose crown. The reimbursement shall be at the full amount of the charge, up to a maximum of $100 per episode.

SERVICES NOT COVERED BY THE DPO

- A service started before the person became a covered individual under the plan.
- Replacement of lost, stolen, or damaged prosthodontic devices within two years of the date of initial installation.
- A service not reasonably necessary for the dental care of a covered individual or provided solely for cosmetic purposes.
- Providing supplies of a type normally intended for home use, such as toothpaste, toothbrushes, waterpicks, and mouthwash.
- A service required because of war or an act of war.
- A service made available to a covered individual or financed by the federal, State, or local government. This includes the federal Medicare program and any similar federal program, any Workers' Compensation law or similar law, any automobile no-fault law, or any other program or law under which the covered individual is, or could be, covered. The exclusion is applicable whether or not the covered individual receives the service, makes a claim or receives compensation for the service, or receives a recovery from a third party for damages.
- A service not furnished by a dentist or physician licensed to provide the dental service, except for a service performed by a licensed dental hygienist under the direction of a dentist.
- General anesthesia, except when medically necessary in connection with covered oral and periodontal surgery procedures.
- Hospitalization.
- Any dental implant including any crowns, prostheses, devices, or appliances attached to implants.
- Experimental procedures.
- Appliances, restorations, and procedures to alter vertical dimension and/or restore occlusion, including temporomandibular joint dysfunction, except oral splints.
- Procedures that are not listed.
- A service covered under any medical, surgical, or major medical plan (including a Health Maintenance Organization — HMO) provided by the employer.
- Services and supplies provided in connection with treatment or care that is not covered under the plan.

SECTION FOUR

THE DENTAL EXPENSE PLAN

The Dental Expense Plan (DEP) is an indemnity plan that reimburses for a portion of the expenses incurred for dental care provided by dentists or physicians licensed to perform dental services in the state in which they are practicing. Not all dental services are eligible for reimbursement, and some services are eligible only up to a limited amount (for example, orthodontic services are reimbursed differently than other services)

Diagnostic/preventive and orthodontic services are not subject to an annual deductible. For all other services an annual deductible amount must be met before benefits are payable. You are responsible for making the full payment of all charges to your dentist.

The DEP has been established by the State as a self-funded plan. The State currently contracts with Aetna Dental to act as the administrative agent for the Dental Expense Plan.

As a DEP member, you may be able to take advantage of a special Aetna network of participating dental providers. In this network, participating dental providers contract with Aetna for a discounted fee schedule. When using a participating dental provider, you only pay the provider any applicable deductible and the appropriate coinsurance based on the discounted fee, thereby reducing your out-of-pocket cost. In many cases the participating dental provider will submit the claims directly to Aetna, eliminating the necessity of filing claim forms.

To find out if your provider participates in the discounted network, call Aetna at 1-877-STATENJ (1-877-782-8365) or visit Aetna's website at: ***www.aetna.com***

Annual Deductible

Diagnostic/preventive and orthodontic services are not subject to a deductible amount.

For other services, the first $50 of covered expenses that you or your dependent(s) incur in a calendar year is not eligible for reimbursement. However, if there are four or more members of your family in the DEP, no additional deductibles are charged after any three members have each met their $50 deductible.

Reasonable and Customary Charges

The DEP covers only that part of a provider's charge for a service or supply that is reasonable and customary. Generally speaking, a charge by your dentist, or by any other provider of services or supplies, is considered reasonable and customary if it doesn't exceed the pre-

vailing charge for the same service or supply made by similar providers in the same geographic area; it may differ from the actual amount that your dentist charges. You are responsible for the amount the dentist charges above the reasonable and customary allowances.

Dental Expense Plan Benefits

	In-Network	Out-of-Network
Deductible / Calendar Year	$50 / Individual $100 / Family Waived for Preventive Care	$75 / Individual $150 / Family Waived for Preventive Care
Coinsurance (as percentage of reasonable and customary charges)	100% Preventive 80% Basic Restorative 65% Major Restorative 50% Periodontics & Prosthodontics	90% Preventive 70% Basic Restorative 55% Major Restorative 40% Periodontics & Prosthodontics
Maximum Annual Benefit / Individual	$3,000	$2,000; maximum of $3,000 combined in- and out-of-network
Orthodontic Services Under Age 19	50% to $1,000 lifetime maximum; not subject to deductible; maximum not combined with Annual Maximum	40% to $750 lifetime; maximum of $1,000 combined in- and out-of-network; not subject to deductible; maximum not combined with Annual Maximum

COVERED SERVICES

A general description of each category of service is provided below. Refer to the "Services Eligible for Reimbursement" section for any limitations that may apply to these services.

Diagnostic and Preventive Services are precautionary services, and are intended to maintain oral health and reduce the effects of tooth decay or gum disease which could lead to an increased need for more costly restorative services. They include the following:

- Oral Evaluations (includes comprehensive, periodic, limited, and specialist oral evaluations);
- Prophylaxis (cleaning of the teeth, including scaling and polishing procedures);
- Fluoride Treatments (topical application of fluoride for children under age 19);
- X-rays (limitations may apply); and
- Laboratory and other diagnostic tests.

Basic Services include:

- Emergency Treatment (Palliative only);
- Space Maintainers (i.e., passive appliances — fixed or removable);
- Simple Extractions;
- Surgical Extractions;
- Oral Surgery;
- Anesthesia Services;
- Basic Restorations (i.e., amalgam restorations and resin restorations);
- Endodontics (i.e., treatment of diseases of the dental pulp, including root canal and associated therapy); and
- Repairs to removable dentures.

Major Restorative Services include those services that restore existing teeth. These services are utilized only if a tooth cannot be restored with an amalgam, acrylic, synthetic porcelain, or composite filling restoration. Inlays, onlays, and crowns are typical examples of major restorative services.

Periodontal Services include those services involving the maintenance, reconstruction, regeneration, and treatment of the supporting structures surrounding teeth, including bone, gum tissue, and root surfaces.

Prosthodontic Services include both removable and fixed dentures (bridges) replacing missing teeth.

Orthodontic Services include services to correct abnormalities in tooth position (malposition) or abnormal bite (malocclusion), using appliances such as retainers or braces.

Annual and Lifetime Benefit Maximums

The most the Dental Expense Plan will pay for any one person in any one calendar year is $3,000 — combined in-network and out-of-network. This maximum applies to all eligible services except orthodontic, which has a separate $1,000 lifetime benefit maximum.

In-Network and Out-of-Network Integration

The in-network maximum is $3,000 and the out-of-network maximum is $2,000, and the two maximums are integrated. This means that if you receive services out-of-network and reach the out-of-pocket maximum of $2,000, the $2,000 carries forward towards the $3,000 in-network maximum, leaving only $1,000 remaining for in-network services. Examples of how in-network and out-of-network claims are paid are shown in the following charts.

ADDITIONAL PROVISIONS OF THE DEP

How Payments Are Made

Normally, any reimbursements will be made to the DEP subscriber. The DEP subscriber may, however, authorize Aetna to send the reimbursement directly to the dental provider by completing the appropriate part of the claim form.

Additionally, whenever a law or court order requires the payment of dental expense benefits under the DEP to be made to a person or facility other than the DEP subscriber, the payment will be made to that person or facility upon proper notification (letter and a copy of the order/law).

Filing Deadline — Proof of Loss

Aetna must be given written proof that a dental service has been performed for which a claim is made under the coverage. This proof must cover the occurrence, character, and extent of the service. It must be furnished within 27 months of the date of service. For example, if a service were incurred on February 1, 2019, you would have until April 30, 2021, to file the claim.

A claim will not be considered valid unless proof of the service is furnished within the time limit indicated above. If it is not possible for you to provide proof within the time limit, the claim may be considered valid upon appeal if the reason the proof was not provided in a timely basis was reasonable.

In-Network Claims

Procedure	Provider Charge	DEP Allowance	Deductible	Coinsurance	Plan Pays	Member Pays
Abutment	$1,250.00	$785.00	$50.00	50%	$367.50	$417.50
Pontic	$1,250.00	$785.00	$0.00	50%	$392.50	$392.50
Abutment	$1,250.00	$726.00	$0.00	50%	$363.00	$363.00
Totals	$3,750.00	$2,296.00	$50.00	—	$1,123.00	$1,173.00

Out-of-Network Claims

Procedure	DDS Charge	PPO Allowance	Deductible	Coinsurance	Plan Pays	Member Pays
Abutment	$1,250.00	$1,150.00	$75.00	40%	$430.00	$820.00
Pontic	$1,250.00	$1,150.00	$0.00	40%	$500.00	$750.00
Abutment	$1,250.00	$1,150.00	$0.00	40%	$500.00	$750.00
Totals	$3,750.00	$3,450.00	$75.00	—	$1,430.00	$2,320.00

Itemized Bills Are Necessary

You must obtain itemized bills from the providers of services for all dental expenses. The itemized bills must include the following:

- Name and address of provider;
- Provider's tax identification number;
- Name of patient;
- Subscriber's identification number;
- Date of service;
- Type of service;
- Procedure code (CDT-2020 Code); and
- Charge for each service.

Predetermination of Benefits

Predetermination is voluntary and allows you to know what services are covered and what payments will be made for treatment before the work is done. If you or one of your dependents are likely to incur dental expenses over $300, it is strongly recommended that you ask your dentist to file for predetermination of benefits.

This feature of the DEP ensures that both you and the dentist will know in advance what part of the dentist's charges the DEP will pay. If possible, treatment should be completed within 90 days of receiving the approved predetermination.

The predetermination of benefits provision of the DEP is important, because under the alternative procedures provision (see the "Alternative Procedures" section), Aetna has the right to pay the reasonable and customary allowance for the method of treatment that is proper and is economically sound.

How Predetermination of Benefits Works — Your dentist submits a treatment plan and Aetna determines the amount the DEP will pay, and informs you and the

dentist of its payment decision. You and your dentist should discuss the predetermination before the work is started.

Predetermination of benefits will help you avoid surprises. Most dentists are familiar with predetermination procedures; if not, they should call Aetna at 1-877-STATENJ (1-877-782-8365). If your dentist submits a treatment plan for predetermination of benefits and then alters the course of treatment, Aetna will adjust its payments accordingly. If the dentist makes a major change in the treatment plan, he or she should send in a revised plan.

Alternative Procedures

Usually there are several ways to treat a particular dental problem. Payment will be based on the least costly treatment as determined by Aetna so long as the treatment meets acceptable dental standards. If you and the dentist decide you want a more costly treatment method, you are responsible for the charges beyond those for the less costly, appropriate treatment.

SERVICES ELIGIBLE FOR REIMBURSEMENT

Even though a service or supply may not be described or listed in this handbook, that does not make the service or supply eligible for a benefit under this plan.

- Oral evaluations (limited to twice in a calendar year). Emergency or limited oral evaluations are limited to once in a calendar year, per patient — covered at 100 percent of the reasonable and customary charges.
- X-rays (horizontal bitewing X-rays limited to two series of up to four films in a calendar year; vertical bitewing X-rays limited to two series of up to eight films per calendar year; set of full mouth or panoramic X-rays limited to once per 36-month interval; no more than 18 films per set of full mouth periapical X-rays).
- Oral prophylaxis, including scaling (not including scaling performed by a periodontist) and polishing (limited to twice in a calendar year).
- Topical application of fluoride for children under age 19 limited to twice in a calendar year.
- Sealants (limited to once per lifetime for permanent molars of eligible dependent children under the age of 19 years).
- Prosthodontic procedures (the replacement of an existing fixed or removable prosthetic appliance is covered only after a five-year period, measured from the date on which the appliance was previously placed).
- Periodontic procedures (reimbursement for periodontal surgical procedures and follow-up maintenance, usually provided for a specific quadrant, is limited to one surgical-type procedure every 36 months). Reimbursement for periodontal scaling and root planing procedures per specific quadrant is limited to one procedure per 12-month interval.
- Restorative procedures, including fillings, inlays, onlays, and crowns (the replacement of a crown is covered only after a five-year period measured from the date on which the crown was previously placed).
- Emergency palliative treatment.
- Extractions of teeth.
- Endodontic services, such as pulpotomy and root canal therapy.
- Space maintainers.
- Oral surgery for surgical extractions, treatment of fractures, removal of lesions of the mouth, alveolectomy, and biopsy of hard and soft tissue.
- Apicoectomy.
- General anesthesia (including conscious sedation coverage) when medically necessary and in connection with covered oral and periodontal surgical procedures.

ORTHODONTIC SERVICES ELIGIBLE FOR REIMBURSEMENT

Certain charges for orthodontic procedures are eligible if:

- You have been a full-time employee for at least 10 months;
- The orthodontic treatment is for a child covered under the DEP who is less than 19 years old;
- The procedure involves the use of active appliances to move teeth in order to correct the faulty position of teeth (malposition) or abnormal bite (malocclusion);
- The service or supply is part of a treatment plan submitted by the dentist and approved by Aetna with an estimate of the benefits that are payable;
- The service or supply is furnished before the end of the estimated duration of the treatment as recorded in the treatment plan; and
- An active appliance for the procedure is inserted while the person is eligible for benefits in this program.

Orthodontic Benefits

In-Network Eligible orthodontic services will be covered at 50 percent, up to a lifetime benefit maximum of $1,000.

Out-of-Network orthodontic services will be covered at 40 percent, up to a lifetime benefit maximum of $750 (maximum of $1,000 combined in- and out-of-network).

There is no deductible for orthodontic services. See the "Orthodontic Charges Not Eligible Under the DEP" section.

SERVICES NOT ELIGIBLE FOR REIMBURSEMENT

- Any orthodontic service prior to the employee attaining 10 months of employment, or for any member over 19 years of age.
- Gold restorations other than crowns, inlays, and onlays.
- Any service or item not reasonably necessary for the dental care of the patient.
- Endosteal, subperiosteal, and transosteal tooth implants.
- Protective devices such as athletic mouth guards, plaque control, or myofunctional therapy.
- Services and/or appliances that are for the primary purpose of altering vertical dimension (change the way natural teeth meet), including full mouth rehabilitation (crowning all or most of the teeth), splinting teeth with crowns, fillings, appliances, or any method or service that restores occlusion or incisal tooth structure lost from attrition, erosion, abrasion, or any other cause.
- Crowns, inlays, and onlays if used in splinting procedures during periodontal treatment.
- A service for cosmetic purposes.
- Any charge for a supply that is normally for home use such as toothpaste, toothbrushes, water-pick, or mouthwash.
- A dental examination when required as a condition of employment by an employer, a government agency, or the terms of a labor agreement.
- Charges for services that are not reasonably necessary made to produce a professionally acceptable result.
- A service or supply due to a war or any act of war.
- A service not furnished by a dentist or physician licensed to provide the dental service, except for a service performed by a licensed dental hygienist under the direction of a dentist.
- A service rendered by a provider that is beyond the scope of the provider's license.
- A charge made by a dentist for a failure of the patient to keep an appointment.
- A charge for the completion of any claim forms.
- A charge in connection with any procedure started before the patient was eligible for reimbursement in this program; except that a procedure will not have been considered to have started with an oral prophylaxis or a diagnostic procedure.
- Any service or supply other than those specifically covered under this program.
- Hospitalization.
- Experimental procedures.
- A service covered under any medical, surgical, or major medical plan (including a Health Maintenance Organization (HMO)) provided by the employer.
- A service made available to a covered individual or financed by the federal, State, or local government. This includes the federal Medicare program and any similar federal program, any Workers' Compensation law or similar law, any automobile no-fault law, or any other program or law under which the covered individual is, or could be, covered. The exclusion is applicable whether or not the covered individual receives the service, makes a claim or receives compensation for the service, or receives a recovery from a third party for damages.
- Any charge incurred after the patient is no longer covered, except in the case of an Extension of Coverage.
- Any charge for a service that is more than the reasonable and customary dental charge.
- Any charge for a service rendered by a member of the patient's immediate family (including you, your spouse or civil union/domestic partner, your child, brother, sister, or parent of you or spouse/partner).
- Charges for sterilization or asepsis.
- Services and supplies provided in connection with treatment or care that is not covered under the plan.

Orthodontic Charges Not Eligible Under the DEP

- Charges that are eligible for coverage under the regular dental care portion of the program.
- Charges for an orthodontic procedure started prior to the day on which the person became covered under the program or eligible for orthodontic benefits.
- Charges not reasonably necessary for orthodontic care.
- Any charges incurred for orthodontic procedures or treatment begun on or after the date the person attains age 19.

APPENDIX I

CLAIM APPEAL PROCEDURES

You or your authorized representative may appeal and request that your dental plan reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be of an administrative or dental nature. Administrative appeals might question eligibility or plan benefit decisions such as whether a particular service is covered or paid appropriately. Dental appeals refer to the determination of dental need, appropriateness of treatment, or experimental and/or investigational procedures.

The following information must be given at the time of each inquiry:

- Name(s) and address(es) of patient and employee;
- Employee's identification number;
- Date(s) of service(s);
- Provider's name and identification number;
- The specific remedy being sought; and
- The reason you think the claim should be reconsidered.

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

Any member of the DEP who disagrees with a final decision of Aetna may request, in writing, that the matter be considered by the SHBC. Requests for consideration must be directed to the Appeals Coordinator, State Health Benefits Commission, P.O. Box 299, Trenton, NJ 08625-0299, and must contain the reason for the disagreement and a copy of all relevant correspondence. Appeals are considered at regular meetings of the Commission. It is the responsibility of the member to provide the Commission with any medical or other information that the Commission may require in order to make a decision.

Upon request, your DPO will supply you with its appeal procedures. Any member of a DPO who disagrees with a determination of the appropriateness of a procedure made by a DPO, or any member of a DPO who feels that the DPO has violated the terms and conditions of its contract with the SHBP, may request in writing that the matter be considered by the Commission. Such an appeal can only be considered after the member has exhausted the DPO's grievance process. Requests for consideration must be directed to the *Appeals Coordinator, State Health Benefits Commission, P.O. Box 299, Trenton, NJ 08625-0299,* and must contain the reason for the disagreement and a copy of all relevant correspondence and supporting documentation.

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps that may be taken in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request, within 45 days and in writing to the Commission, that the case be forwarded to the Office of Administrative Law (OAL). The Commission will then determine if a factual hearing is necessary. If so, the case will be forwarded to the OAL. An Administrative Law judge will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify, or reject. If a factual hearing is not necessary, the administrative appeal process involving the Commission is ended. When the administrative process is completed, further appeals may be made to the Superior Court of New Jersey, Appellate Division.

If your case is forwarded to the OAL, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. If you take your appeal to Superior Court, you will be responsible for any court filing fees or similar related costs that may be necessary during the appeal process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

APPENDIX II

GLOSSARY

Alveolectomy — Surgical excision of a portion of the dentoalveolar process, for re-contouring the tooth socket ridge at the time of tooth removal in preparation for a dental prosthesis (denture).

Amalgam — An alloy used in dental restoration.

Apicoectomy — Surgical removal of a dental root apex. Root resection.

Bitewing X-Ray — X-rays taken with the film holder held between the teeth and the film parallel to the teeth.

Calendar Year — A year starting January 1 and ending on December 31.

Coinsurance — The portion of an eligible charge which is the member's financial responsibility.

Coordination of Benefits — The practice of correlating the payments a plan makes with payments provided by other insurance covering the same charges or expenses, so that (1) the plan with primary responsibility pays first, (2) reimbursement by the two plans does not exceed 100 percent of the allowable expense, and (3) the dental plan does not pay more than it would if no other insurance existed.

Copayment — The portion of an eligible charge under a DPO which is the member's financial responsibility.

Crossbite — An abnormal relation of one or more teeth of one arch to the opposing tooth or teeth of the other arch.

Crown — That part of a tooth that is covered with enamel or an artificial substitute for that part.

Deductible — The first eligible expense, or portion thereof, incurred within each calendar year that the member is required to pay before reimbursement for eligible expenses begins.

Dependent Coverage — Coverage of an eligible family member of an enrolled member.

Employer — The State, or a local public employer which participates in the SHBP or SEHBP.

Endodontics — Concerned with the biology and pathology of the dental pulp and surrounding tissues. Root canal treatment.

Gingivectomy — Removal of gum tissue.

Gingivoplasty — A surgical procedure that reshapes and recontours the gum tissue in order to attain functional form.

Inlay — A cast metallic or ceramic filling for a dental cavity.

Mandibular — Relating to the lower jaw.

Maxillary — Relating to the upper jaw.

Member — With respect to the Employee Dental Plans, employees and any dependents who are eligible to enroll in the SHBP/SEHBP Active Group, Retired Group, or COBRA.

Myofunctional — Relating to the role of muscle function in the correction of oral problems.

Onlay — A type of metal or ceramic restoration that overlays the tooth to provide additional strength to that tooth.

Orthodontic — Concerned with the correction and prevention of irregularities of the teeth. Dental orthopedics.

Osteoplasty — Resection of the bony structure to achieve acceptable gum contour.

Palliative Treatment — Alleviation of symptoms without curing the underlying disease.

Periodontics — Concerned with the treatment of abnormal conditions and diseases of the tissues that surround and support the teeth.

Pontic — An artificial tooth on a fixed partial denture.

Prophylaxis — A series of procedures whereby calculus (calcified deposits), stain, and other accretions are removed from the clinical crowns of the teeth and the enameled surfaces are polished.

Prosthodontics — The science of and art of providing suitable substitutes for crowns of teeth, or for replacing lost or missing teeth.

Pulpotomy — Removal of a portion of the pulp structure of a tooth, usually the coronal portion.

Reasonable and Customary — A charge by a dentist, or by any other provider of services or supplies, that does not exceed the prevailing charge for the same service or supply made by similar providers in the same geographic area. The member is responsible for any amount a dentist or provider charges above the reasonable and customary allowance.

Resin — A material used in dental restoration.

Scaling and Root Planing — The removal of subgingival calcified deposits around the teeth and the cleaning of the gingival pocket.

Temporomandibular — Denoting the joint of the lower jaw.

APPENDIX III

AVAILABLE DENTAL PLANS

Plan Number	Plan Name	Web Addresses and Membership Services Phone Number
305	**CIGNA Dental Health, Inc.**	***www.cigna.com/sites/stateofnjdental*** 1-800-564-7642
307	**Healthplex** (International Health Care Services)	***www.healthplex.com*** 1-800-468-0600
317	**Horizon Dental Choice**	***www.horizonblue.com*** 1-800-433-6825
319	**Aetna DMO**	***www.aetna.com/statenj*** 1-800-843-3661
320	**MetLife**	***www.metlife.com/dental*** 1-866-880-2984
399	**Dental Expense Plan** (PPO Administered by Aetna)	***www.aetna.com/statenj*** 1-877-STATENJ (1-877-782-8365)

APPENDIX IV

TAX$AVE

Tax$ave is a benefit program, defined by Section 125 of the federal Internal Revenue Code (IRC), for eligible New Jersey State employees to use pre-tax dollars to pay for qualified medical, dental, and dependent care expenses and thereby increase their take-home pay. The pre-tax deduction effectively reduces the salary on which taxes are computed by the amount of the health, dental, or dependent care deduction.

Note: The Tax$ave program is not available to local employees. Contact your employer to find out if you are eligible to pay premiums on a pre-tax basis through an IRC Section 125 Program offered by your employer. For more information, see the *Tax$ave* Fact Sheet.

APPENDIX V

NOTICE OF PRIVACY PRACTICES TO ENROLLEES

This Notice describes how medical (and dental) information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Protected Health Information

The State Health Benefits Program and School Employees' Health Benefits Program (Programs) are required by the federal Health Insurance Portability and Accountability Act (HIPAA) and State laws to maintain the privacy of any information that is created or maintained by the programs that relates to your past, present, or future physical or mental health. This Protected Health Information (PHI) includes information communicated or maintained in any form. Examples of PHI are your name, address, Social Security number, birth date, telephone number, fax number, dates of health care service, diagnosis codes, and procedure codes. PHI is collected by the Programs through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The Programs are required by law to abide by the terms of this Notice. The Programs reserve the right to change the terms of this Notice. If material changes are made to this Notice, a revised Notice will be sent.

Uses and Disclosures of PHI

The Programs are permitted to use and to disclose PHI in order for our members to obtain payment for health care services and to conduct the administrative activities needed to run the Programs without specific member authorization. Under limited circumstances, we may be able to provide PHI for the health care operations of providers and health plans. Specific examples of the ways in which PHI may be used and disclosed are provided below. This list is illustrative only and not every use and disclosure in a category is listed.

- The Programs may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The Programs may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The Programs receive PHI from employers, including the member's name, address, Social Security number, and birth date. This enrollment information is provided to our Business Associates so that they may provide coverage for health care benefits to eligible members.
- The Programs and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.
- The Programs may provide PHI to a provider, a health care facility, or a health plan that is not our Business Associate that contacts us with questions regarding the member's health care coverage.
- The Programs may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The Programs may use and disclose PHI for fraud and abuse detection.
- The Programs may allow use of PHI by our Business Associates to identify and contact our members for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services, or about treatment alternatives that may be of interest to them.
- In the event that a member is involved in a lawsuit or other judicial proceeding, the Programs may use and disclose PHI in response to a court or administrative order as provided by law.
- The Programs may use or disclose PHI to help evaluate the performance of our health plans. Any such disclosure would include restrictions for any other use of the information other than for the intended purpose.
- The Programs may use PHI in order to conduct an analysis of our claims data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

Except as described above, unless a member specifically authorizes us to do so, the Programs will provide access to PHI only to the member, the member's

authorized representative, and those organizations who need the information to aid the Programs in the conduct of its business (our "Business Associates"). An authorization form may be obtained online at: ***www.nj.gov/treasury/pensions*** or by sending an email to: ***hipaaform@treas.nj.gov*** A member may revoke an authorization at any time.

Restricted Uses

- PHI that contains genetic information is prohibited from use or disclosure by the Programs for underwriting purposes.
- The use or disclosure of PHI that includes psychotherapy notes requires authorization from the member.

When using or disclosing PHI, the Programs will make every reasonable effort to limit the use or disclosure of that information to the minimum extent necessary to accomplish the intended purpose. The Programs maintain physical, technical, and procedural safeguards that comply with federal law regarding PHI. In the event of a breach of unsecured PHI the member will be notified.

Member Rights

Members of the Program have the following rights regarding their PHI.

Right to Inspect and Copy: With limited exceptions, members have the right to inspect and/or obtain a copy of their PHI that the Programs maintain in a designated record set, which consists of all documentation relating to member enrollment and the Programs' use of this PHI for claims resolution. The member must make a request in writing to obtain access to their PHI. The member may use the contact information found at the end of this Notice to obtain a form to request access.

Right to Amend: Members have the right to request that the Programs amend the PHI that we have created and that is maintained in our designated record set.

We cannot amend demographic information, treatment records, or any other information created by others. If members would like to amend any of their demographic information, please contact your personnel office. To amend treatment records, a member must contact the treating physician, facility, or other provider that created and/or maintains these records.

The Programs may deny the member's request if: 1) we did not create the information requested on the amendment; 2) the information is not part of the designated record set maintained by the Programs; 3) the member does not have access rights to the information; or 4) we believe the information is accurate and complete. If we deny the member's request, we will provide a written explanation for the denial and the member's rights regarding the denial.

Right to an Accounting of Disclosures: Members have the right to receive an accounting of the instances in which the Program or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years. We will provide the member with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those made for treatment, payment or health benefits operation purposes, or made in accordance with an authorization) and will not appear on the accounting.

Right to Request Restrictions: The member has the right to request that the Programs place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The Programs are not required to agree to any restrictions and in some cases will be prohibited from agreeing to them. However, if we do agree to a restriction, our agreement will always be in writing and signed by the Privacy Officer. The member request for restrictions must be in writing. A form can be obtained by using the contact information found at the end of this Notice.

Right to Restrict Disclosure: The member has the right to request that a provider restrict disclosure of PHI to the Programs or Business Associates if the PHI relates to services or a health care item for which the individual has paid the provider in full. If payment involves a flexible spending account or health savings account, the individual cannot restrict disclosure of information necessary to make the payment but may request that disclosure not be made to another program or health plan.

Right to Receive Notification of a Breach: The member has the right to receive notification in the event that the Programs or a Business Associate discover unauthorized access or release of PHI through a security breach.

Right to Request Confidential Communications: The member has the right to request that the Programs communicate with them in confidence about their PHI by using alternative means or an alternative location, if the disclosure of all or part of that information to another person could endanger them. We will accommodate such a request if it is reasonable, if the request specifies the alternative means or locations, and if it continues to permit the Programs to collect premiums and pay claims under the health plan.

To request changes to confidential communications, the member must make their request in writing and must clearly state that the information could endanger them if it is not communicated in confidence as they requested.

Right to Receive a Paper Copy of the Notice: Members are entitled to receive a paper copy of this Notice. Please contact us using the information at the end of this Notice.

Questions and Concerns

If you have questions or concerns, please contact the Programs using the information listed at the end of this Notice (local county, municipal, and board of education employees should contact the HIPAA Privacy Officer for their employer).

If members think the Programs may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the use or disclosure of their information, or to have the Programs communicate with them in confidence by alternative means or at an alternative location, they must submit their complaint in writing. To obtain a form for submitting a complaint, use the contact information found at the end of this Notice.

Members also may submit an online complaint to the U.S. Department of Health and Human Services, at: ***www.hhs.gov/hipaa/filing-a-complaint***

The Programs support member rights to protect the privacy of PHI. It is your right to file a complaint with the Programs or with the U.S. Department of Health and Human Services.

Contact Office:

The New Jersey Division of Pensions & Benefits
HIPAA Privacy Officer

Address:

New Jersey Division of Pensions & Benefits
Bureau of Policy and Planning
P.O. Box 295
Trenton, NJ 08625-0295

Email: ***hipaaform@treas.nj.gov***

HEALTH BENEFITS CONTACT INFORMATION

Addresses

Our mailing address is:

New Jersey Division of Pensions & Benefits
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-0299

Our website address is:

www.nj.gov/treasury/pensions

Our email address is

pensions.nj@treas.nj.gov

Telephone Numbers

Division of Pensions & Benefits

Office of Client Services ..... (609) 292-7524

Relay Operator (Hearing Impaired)
Dial 711 and provide
operator with: ..... (609) 292-6683

State Employee Advisory Service (EAS)

1-866-327-9133

Rutgers University Personnel Counseling Service

RBHS-Newark..... (973) 972-5429

RBHS-Piscataway..... (732) 235-5930

Rutgers-Camden ..... (856) 770-5750

New Jersey State Police

Office of Employer and
Organization Development 1-800-367-6577

New Jersey Department of Banking and Insurance

Individual Health Coverage
Program Board..... 1-800-838-0935

Consumer Assistance for
Health Insurance..... (609) 292-5316

Independent Health Care
Appeals Program 1-800-466-7467

New Jersey Department of Human Services

Pharmaceutical Assistance to the
Aged and Disabled (PAAD) 1-800-792-9745

Division on Senior Affairs..... 1-800-792-8820

Insurance Counseling..... 1-800-792-8820

Centers for Medicare and Medicaid Services

New Jersey Medicare —
Part A and Part B 1-800-MEDICARE

HEALTH BENEFITS PUBLICATIONS

Publications and fact sheets available from the NJDPB provide information on a variety of subjects. Fact sheets, guidebooks, applications, and other publications are available for viewing or downloading on our website.

General Publications

Summary Program Description — An overview of SHBP/SEHBP eligibility and plans

Plan Design Comparison Charts — Out-of-pocket cost comparison charts for State employees, local government employees, local education employees, and all retirees

Health Benefit Fact Sheets

- *Health Benefits Coverage — Enrolling as a Retiree*
- *Health Benefit Programs and Medicare Parts A & B for Retirees*
- *Termination of Employment through Resignation, Dismissal, or Layoff*
- *COBRA — The Continuation of Health Benefits*
- *Dental Plans — Active Employees*
- *Health Benefits Retired Coverage under Chapter 330*
- *Family Status Changes - Employees*
- *Family Status Changes - Retirees*
- *Health Benefits Coverage Continuation for Over Age Children With Disabilities*
- *Health Benefits Coverage for Part-Time Employees*
- *Health Benefits Coverage for State Intermittent Employees*
- *Dental Plans — Retirees*
- *Health Benefits Coverage of Children until Age 31 under Chapter 375*
- *Civil Unions and Domestic Partnerships*

Health Plan Member Guidebooks

- *NJ DIRECT/CWA Unity DIRECT Member Guidebook*
- *Horizon HMO Member Guidebook*
- *Horizon OMNIA Member Guidebook*
- *Prescription Drug Plans Member Guidebook*
- *NJ DIRECT HDHP Member Guidebook*
- *Employee Dental Plans Member Guidebook*
- *Retiree Dental Plans Member Guidebook*