Horizon

Horizon Blue Cross Blue Shield of New Jersey

HORIZON DENTAL OPTION PLAN

GLOUCESTER CITY PUBLIC SCHOOLS

#96737-00,01

YOUR DENTAL PROGRAM

Index

Administered by
Horizon Healthcare Dental Services, Inc.
#96737-00

This booklet contains a brief general description of the benefits available to you under the contract issued to your group by Horizon Blue Cross Blue Shield of New Jersey. The benefits described are subject to all the terms, conditions, limitations and definitions in the contract, as well as all provisions required by State Law. In the event there appears to be a contradiction between the benefits described in this booklet and those provided in the group contract, the group contract shall prevail.

SERVICE CENTERS

If you have questions about this program, call Our Service Center at (800) 433-6825. Telephone personnel are available Monday through Friday from 8:00 am to 6:00 pm. Always have your identification card handy when calling Us. Your ID number helps Us get prompt answers to your questions about enrollment, benefits or claims.

HOW THE HORIZON DENTAL OPTION PLAN WORKS:

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

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

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

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

Non Participating Dentists: A Non Participating Dentist is any licensed Dentist who does not have an agreement with Horizon.

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

DEFINITIONS

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

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

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

Participating Dentist. A Dentist who has a written agreement with Us.

Non Participating Dentist. A Dentist who does not have an agreement with Us.

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

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

GENERAL INFORMATION

How To Enroll: You may enroll in the program by completing an enrollment card. If you enroll your dependents, their coverage will become effective on the same date as your own coverage. The date is shown on your identification card. If you don't apply for coverage for yourself or your dependents when you first become eligible (or if you end your coverage), you must wait for a later open enrollment period to enroll. This open enrollment period must be at least 12 months after the last time you could have obtained coverage if you didn't apply, or at least 12 months after the date you ended your coverage.

Your Identification Card: You will receive a Dental identification card to show the Dentist when you use your Dental benefits. Your identification card shows the group through which you are enrolled; your type of coverage, your identification number and the effective date you can start to use your benefits. All of your eligible dependents share your identification number.

Eligible Dependents: Your eligible dependents are your spouse and your unmarried children under 23. We consider your children dependents if they are your own, your spouse's natural children, your legally adopted children or a child placed in your home for whom you have begun adoption procedures, or children living with you for whom you are appointed legal guardian by a court and for whom you are financially responsible. Foster children are not included. Coverage for a child ends on the last day of the month in which the child marries or the last day of the calendar year in which the child attains age 23, whichever comes first. In addition, an unmarried handicapped child may remain covered beyond age 23. A handicapped child is one who is incapable of self-sustaining employment because of mental retardation or physical handicap. The child's handicap must have started before he or she became age 23 and the child must depend chiefly on you for support. For the handicapped child to remain covered, you must give Us proof of incapacity within 31 days of the child becoming age 23. The proof must meet Our approval. Once We receive acceptable proof, that child can remain covered as long as the Family coverage is in effect and the handicap continues. Coverage will end on the last day of the benefit year in which the child ceases to qualify as a handicapped child.

Change In Type Of Coverage: If you want to change your type of coverage, see your enrollment official. If your family changes, you should arrange for enrollment changes within 30 days of that family change.

When Your Coverage Ends: Your coverage ends at the end of the month your enrollment ends, or on the last day of the month for which premium charges have been paid by your group. Coverage for a dependent will end when your coverage ends, on the date on which the dependent fails to meet the definition of a dependent, or in the case of an unmarried child, on the last day of the month the child marries or termination age is reached. If your eligibility ends due to total disability, or if you die and leave surviving dependents, continued coverage may be available for some period. See your enrollment official for further details.

Continuation Of Coverage Under COBRA: Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you may have the opportunity to continue group dental coverage which would otherwise end. Your employer is responsible for providing all notices required with respect to this provision.

Contact your employer for any rights for continuation of dental coverage under COBRA.

Coordination of Benefits: Almost all group insurance programs provide for the coordination of benefits. This program will provide its regular benefits in full when it is the primary plan. As a secondary plan, this program will provide a reduced amount which when added to the benefits under other group plans will equal up to 100% of the charges for the patient's eligible expenses covered at least in part by either plan, but in no event will this program's liability as a secondary plan exceed its liability as a primary plan.

How To Obtain Benefits: When you go to the Dentist, show your Dental program identification card. Be sure to discuss charges and payment with the Dentist before services begin. If submission of a Treatment Plan for any services is suggested, have the Dentist complete the Treatment Plan portion of the claim form. Both you and your Dentist will receive Our Pre-Certification indicating possible allowances. *This is not a guarantee of payment but an estimate of the benefits available for the proposed services to be rendered. The submission of additional claims or the revision of a pre-certified Treatment Plan prior to the final payment of this claim or changes in eligibility or plan design may affect the estimate given on the Pre-Certification.*

YOUR DENTAL BENEFITS

Basis Of Payment: Payment under your Dental program will be made based on the Maximum Allowable Charge (MAC), as determined by Us. For any payment percentages that are less than 100%, a Participating Dentist may bill you for the difference up to 100% of MAC. A Participating Dentist must accept 100% of the MAC as payment in full. For Non Participating Dentists, you must pay the difference between Our payment and the Dentist's charge, even if it exceeds the MAC. If your Dentist charges less than the MAC, We will pay the applicable percentage of the actual charge.

PREVENTIVE/DIAGNOSTIC SERVICES - 100% of the Maximum Allowable Charge
You are eligible for the following benefits:
- Comprehensive, limited and non-routine oral examinations, including consultations, twice per calendar year;
- Bitewing X-rays twice per calendar year and full mouth X-rays once every 36 months;
- Prophylaxis including scaling and polishing twice per calendar year;
- Topical application of fluoride, limited to twice per calendar year;
- Space maintainers for children under 23 (1st & 2nd molars only);
- Sealants (eligible for children up to 14 years of age), limited to permanent posterior molars.

BASIC SERVICES - 70% of the Maximum Allowable Charge
You are eligible for the following benefits:
- Simple extractions;
- Fillings consisting of silver amalgam and synthetic restorations (limited to once per tooth per 6 months);
- Emergency dental services;
- Repair of bridges, crowns, and dentures;
- General anesthesia;
- *Oral surgery services;
- *Periodontic services.

MAJOR SERVICES - 50% of the Maximum Allowable Charge
You are eligible for the following benefits:
- *Onlays and crowns for restorative purposes that are *not* splinted or part of a bridge;
- *Partial or complete dentures;
- Adjustments to dentures, including rebasing or relining;
- *Fixed bridges;
- *Abutment crowns and pontics.

**It is suggested that a Treatment Plan and pre-operative X-rays be submitted before services are performed. Root canal therapy also requires post-operative X-rays.*

NO BENEFITS WILL BE PROVIDED FOR:
- Replacement of crowns, dentures, bridges or onlays within 5 years after receiving these services;
- Replacement of any crown, denture, bridge or onlay that is satisfactory or could be made satisfactory;
- Replacement of dentures or bridges due to loss or theft;
- Relining or rebasing initial or replacement dentures if the services are performed within 6 months after insertion of the denture, or for more than one relining or rebasing in any 36-month period.

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

ORTHODONTIC BENEFITS - 50% of the Maximum Allowable Charge
You are eligible for the following benefits:
- One diagnosis and treatment lifetime;
- Active treatment including appliances;
- Retention treatment to a maximum of five visits during the period of time specified in the Treatment Plan.

Payment for orthodontic treatments is made in four installments. The first payment becomes payable when the appliance is installed. Later payments are payable at the end of each six month period. In determining the first installment, Horizon assigns 33% of the charge for the entire course of treatment to the installation of the appliance. The remainder of such charge is prorated over the estimated duration of the orthodontic treatment. These payments are made only for services performed while the person remains insured. If insurance or treatment on a covered person ceases during a period, the amount payable for that period will be prorated. The group who purchased this policy may have purchased it to replace a plan it had with another insurer/ administrator. If this plan replaces another plan which covered orthodontia, the maximum number of months for which benefits are provided for active or retention treatment will be reduced by the number of months of treatment performed before the effective date of this coverage.

NO BENEFITS WILL BE PROVIDED FOR:

- Additional orthodontic benefits which are provided within 5 years of the completion of previously eligible treatment;
- Orthodontic treatment beyond the period of time specified in the Treatment Plan;
- Separate charges for the replacement or repair of any appliance furnished under the Treatment Plan;
- Any orthodontic procedures instituted before the effective date of coverage with Horizon Blue Cross Blue Shield of New Jersey or the group's prior carrier.

No benefits will be provided to an eligible person for Orthodontic services after the last day of the year in which the person attains age 23.

DEDUCTIBLE: There is no deductible for Gloucester City Public Schools, #96737-00,01.

MAXIMUM PAYMENT: We will pay benefits for covered dental expenses up to **$1,000.00** for each eligible person during each calendar year. This maximum is combined for all services except orthodontic services. Orthodontic services will be subject to a separate maximum payment of **$500.00** for covered services during the lifetime of each eligible person.

CLAIMS APPEAL

You or your authorized representative may request Us to reconsider any claim or portion(s) of a claim for which you believe benefits have been wrongly denied based on the terms of your program. Send your request to Horizon Blue Cross Blue Shield of New Jersey, Dental Program, P.O. Box 1938, Newark New Jersey 07101-1938. For each request, include: (1) Name and address of patient and subscriber; (2) Subscriber's ID number; (3) Date(s) of service(s); (4) Claim number; (5) Name and address of Dentist; (6) Reason for claim reconsideration; and (7) any additional information not submitted when the claim was first reviewed. Inquiries should be made within 180 days of the date you were first notified of the action taken to deny all or part of your claim. If legal action is brought against Us for a claim that has been wholly or partially denied, the action must be brought within 12 months of the first denial, or if the claim has been appealed, within 12 months of the denial of the appeal.

EXCLUSIONS UNDER YOUR DENTAL PROGRAM

The following *exclusions* apply to your Dental program:

- Completion of claim forms;
- Experimental or investigative procedures, treatments, facilities, equipment, drugs, devices or supplies;
- Services relating to illness or accidental injury which occurred on the job or which is covered or could have been covered for benefits under workers' compensation, employer's liability, occupational disease or similar law;
- Personal comfort and convenience items;I.V. sedation;
- Services eligible for payment under either federal or state programs (except Medicaid);
- Services performed by an immediate relative;
- Services performed as a result of war, service in the armed forces, riot, insurrection, engaged in illegal occupation or the commission of a felony;
- Any services not specifically listed as covered under this program;

- Replacement of tooth structure lost due to attrition, abrasion or erosion;
- Educational services, such as oral hygiene or dietary instructions;
- Services in connection with plaque control programs;
- Replacement of lost, stolen or broken space maintainers;
- Charges for missed or broken appointments;
- Charges for sterilization fees;
- Gold foil restorations;
- Services performed or items furnished strictly for cosmetic purposes;
- Services relating to Temporomandibular Joint (TMJ) dysfunction syndrome;
- Implantology;
- Services performed by a hospital resident, intern or Dentist who is paid by a hospital or other source, or who is not permitted to charge for services covered under this program; or by anyone who does not qualify as a Dentist as defined in this booklet;
- Services with fees payable to a hospital or other institution; all hospital services;
- Anesthesia or consultation services when given in connection with any service that is not covered;
- Services not dentally necessary, as determined by Our dental staff or consultants. To be eligible for coverage, a service must be required for the prevention, diagnosis or treatment of a dental disease, injury or condition to restore teeth broken down by excessive decay or trauma.
The fact that a procedure is prescribed by your Dentist does not make it dentally necessary or eligible under this program. We can ask for any proof We require (such as X-rays or study models) to decide whether services are dentally necessary.

In addition, the following *restrictions* apply:
a. If more than one Dentist renders services for one dental procedure or course of treatment, We will be liable for no more than if one Dentist rendered the service.
b. Alternative course of treatment - If the Dentist or the eligible person selects a course of treatment more expensive than necessary for good dental care, benefits will be based on a procedure that is consistent with sound professional standards of dental practice which carries a lesser fee.