NJDPB
Pensions & Benefits
Explore Your Benefits

Retiree Dental Plans
Member Guidebook

The Dental Plan Organization and The Dental Expense Plans

For Retired Group Members of the State Health Benefits Program and School Employees' Health Benefits Program

HD-0714-0125

TABLE OF CONTENTS

Introduction 4
Retiree Dental Plans Eligibility 4
Eligible Retirees 4
COBRA Members 4
Waiver of Enrollment for Other Dental Coverage 5
Eligible Dependents 5
Enrolling in the Retiree Dental Plans 5
How to Enroll 5
Enrolling Dependents 5
Levels of Coverage 5
Dual Dental Plan Enrollment is Prohibited 5
Retiree Dental Plan Premiums 6
When Coverage Begins 6
End of Coverage 6
Survivor Coverage 6
Extension of Coverage Provisions 6
If Eligibility Ends While Undergoing Treatment 7
For Children Over the Age of 26 With Disabilities 7
Coordination of Benefits With Other Insurance Plans 7
The Retiree Dental Plan Organization 7
Considerations When Choosing a DPO 8
Retiree DPO Reimbursement Tiers 8
Covered Services 9
More Expensive Services 18
Emergency Services — Out of Area 18
Services Not Covered by the DPO 18
Retiree Dental Expense Plans 18
Deductibles 18
Discounted Fee-for-Service Network 18
Reasonable and Customary Allowance 19
Reimbursement 19
Annual Benefit Maximum 19
Plan Design 19
Three Tier Benefit Design 19
Covered Services 19
Preventive Care 19
Basic Services 19
SHBP Retiree Dental Expense Plan Reimbursement Tiers (Chart) 20
Major Restorative Services 20
Additional Provisions of the Plan 20
How Payments Are Made 20
Filing Deadline 21
Itemized Bills 21
Predetermination of Benefits/ Pretreatment Estimate 21
Alternative Procedures 21
SHBP DEP Services Eligible For Reimbursement 21
SHBP DEP Services Not Eligible For Reimbursement 22
SHBP DEP and DEP Plus Plans 23
Deductibles 23
Discounted Fee for Service Network 23
Reasonable and Customary Allowance 23
Reimbursement 23
Annual Benefit Maximum 23
Plan Design 23
DEP - Three Tier Benefit Design 23
DEP Plus - Four Tier Benefit Design 23
Covered Services 24
Preventative Care 24
Basic Services 24
Major Restorative Services 24
Additional Provisions of the Plan 24
How Payments Are Made 24
SEHBP Retiree DEP/DEP Plus Reimbursement Tiers (Chart) 25
Filing Deadline - Proof of Loss 26
Itemized Bills are Necessary 26
Predetermination of Benefits/ Pretreatment Estimate 26
Alternative Procedures 26
SEHBP DEP/DEP Plus Services Eligible for Retirement 26
Orthodontic Services Eligible for Reimbursement (DEP Plus Only) 27
Orthodontic Benefits 27
SEHBP DEP/DEP Plus Services Not Eligible for Reimbursement 27
Orthodontic Charges Not Eligible Under the SEHBP DEP Plus 28
Appendix I 29
Claim Appeal Procedures 29
HIPAA Privacy 30
Audit of Dependent Coverage 30
Health Care Fraud 30
Appendix II 30
Glossary 30

Appendix III 31
Notice of Privacy Practices to Enrollees 30
Protected Health Information 30
Uses and Disclosures of PHI 31
Restricted Uses 32
Member Rights 32
Questions and Concerns 32
Appendix IV 33
Participating Retiree Dental Plans 33
Health Benefits Contact Information 34
Addresses 34
Telephone Numbers 34
Health Benefit Publications 34

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 & 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 Retiree Dental Plans are available to retirees eligible for enrollment in the SHBP or the SEHBP. Before making any enrollment decision, you should carefully review the standards of eligibility and the conditions, limitations, and exclusions of the coverage offered under the plans.

Every effort has been made to ensure the accuracy of the *Retiree 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 (609) 292-7524, or send email to: ***pensions.nj@treas.nj.gov***

RETIREE DENTAL PLANS ELIGIBILITY

Eligible Retirees

Enrollment in the Retiree Dental Plans is voluntary. You have one opportunity to enroll in a Retiree Dental Plan when you first become eligible for Retired Group SHBP or SEHBP health plan coverage. A retiree must submit a SHBP/SEHBP Retiree Dental Plan Application online through Benefitsolver within 60 days of retirement or when first eligible for enrollment or lose the ability to enroll (except as specifically stated in the "Waiver of Enrollment for Other Dental Coverage" section). Benefitsolver can be accessed by navigating to mynjbenefitshub or by logging into your myNewJersey account.

The Retiree Dental Plans are available to the following:

- Any retiree, including surviving eligible dependents, enrolled in a health plan in the Retired Group of the SHBP or SEHBP.
- Eligible retirees, including surviving eligible dependents, who elect to waive medical coverage because of other SHBP or SEHBP coverage or group coverage provided from another employer, either as a dependent of a spouse, or partner, or through their own employment.

COBRA Members

If at retirement you are eligible to enroll for coverage in the Retired Group of the SHBP or SEHBP, you cannot continue employee dental plan coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). You must choose to enroll in a Retiree Dental Plan within 60 days of retirement or when first eligible if waived for other coverage or you will lose the ability to enroll under Retiree Dental Plan coverage.

Waiver Of Enrollment For Other Dental Coverage

The one-time dental plan enrollment opportunity can be deferred if an otherwise eligible individual has other group dental coverage, either as a dependent of a spouse, civil union partner, or domestic partner, through their own employment under an employer plan, or through an eligible retiree group association. An eligible retiree group association is an association whose membership is limited based on the former employment of the retiree or retiree's dependent.

A retiree or eligible survivor may elect to waive enrollment at the time of retirement or first offering and retain the right to enroll at a later date. The individual must enroll online through Benefitsolver within 60 days of the loss of the other group dental coverage.

Proof of the other group dental plan termination of coverage must be submitted online through Benefitsolver in the form of a *HIPAA Certification of Coverage* form or a letter from the employer.

Eligible Dependents

Your eligible dependents are your spouse, civil union partner, or eligible same-sex domestic partner and/or your eligible children.

For definitions of eligible dependents and more information about supporting documentation, visit our website at: ***www.nj.gov/treasury/pensions***

Note: Extended coverage provisions under P.L. 2005, c. 375 (Chapter 375), for certain over age children and the extension of coverage under the provisions of federal COBRA law do not apply to the Retiree Dental Plans. When Retiree Dental Plans coverage ends for yourself or your dependents, there are no other provisions for extending coverage.

ENROLLING IN THE RETIREE DENTAL PLANS

How to Enroll

For new retirees or individuals becoming eligible for Retired Group SHBP or SEHBP coverage, the NJDPB will include dental enrollment materials at the same time it sends the Retired Group health plan offering, which is generally within 30 to 60 days of retirement or eligibility for retiree group plan coverage. The election of dental coverage must be completed online through Benefitsolver by navigating to mynjbenefitshub or via your myNewJersey account.

If you are covered under a group dental plan as a dependent or as an employee through other employment when first offered enrollment, you may opt to waive the Retiree Dental Plans and elect to enroll at a future date if your other coverage has ended. To waive coverage, you must do so online through Benefitsolver. To enroll at a later date, you must submit an online application through Benefitsolver within 60 days of the loss of the other dental coverage. Proof of loss of coverage must be submitted with the online enrollment application. Acceptable documentation includes a letter from the employer providing date of termination of coverage, a *HIPAA Certification of Coverage* form, etc.

Enrolling Dependents

You may enroll your eligible dependents when you enroll.

If you have a new dependent, you may enroll the dependent effective the date you acquired the dependent, provided you submit an online application through Benefitsolver within 60 days of the dependent's eligibility.

If you do not enroll an eligible dependent because of other coverage and that coverage is lost, you can enroll that dependent providing you submit an online application through Benefitsolver within 60 days of the the loss of coverage. A copy of your dependent's *HIPAA Certification of Coverage* form must be submitted with the online enrollment application. Coverage for that dependent will be effective the date of the qualifying event (date of loss of other coverage).

If you do not enroll a dependent within 60 days of eligibility, there will be at least a two-month waiting period from the date the online enrollment is submitted until the dependent is covered. Coverage for that dependent will be effective the first day of the month following a minimum 60-day waiting period. A dependent added in this manner may be added to a retiree's contract only once.

Levels of Coverage

There are four levels of coverage offered through the plan:

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

Dual Dental Plan Enrollment is Prohibited

You and your spouse/partner may be covered under a dental plan as an SHBP or SEHBP eligible employee/retiree or as a dependent, but not as both. For example, if two retirees are married to each other and both are eligible for SHBP and/or SEHBP enrollment, each may elect to enroll for single coverage only, or one retiree may enroll the other as a dependent if the other person waives dental plan coverage. Furthermore, two employees/retirees cannot each enroll the same children as dependents under their respective dental coverage.

Retiree Dental Plans Premiums

Most retirees will pay the full cost of the Retiree Dental Plans. The State does not pay for the cost of coverage. However, under certain circumstances, a local public employer that participates in the SHBP or SEHBP may elect to pay for or share the cost of coverage for its retirees under P.L. 1999, c. 48 (Chapter 48).*

Premium payments are deducted from your monthly pension check. If your monthly pension check amount is not sufficient to cover the full premium, you will be billed monthly in advance of the coverage period.

You will also be billed directly for coverage if you receive a pension not paid by the NJDPB, i.e., the Alternate Benefit Program (ABP).

**Chapter 48 allows some local employers to pay all or a portion of the premium cost of the plan for eligible retirees as a result of collective negotiation agreements. To do this, an eligible employer must file a Chapter 48 Resolution pertaining to the Retiree Dental Plans with the Health Benefits Bureau of the NJDPB. These provisions would not apply to any local retiree who receives retiree health coverage at State (as opposed to local employer) expense.*

When Coverage Begins

Coverage under a Retiree Dental Plan will become effective the same date as your Retired Group health plan coverage, provided that coverage is elected online through Benefitsolver.

- The effective date of coverage for a retiree (and eligible dependents) who was covered for health coverage as an active employee in the SHBP or SEHBP is approximately one month after the date of retirement, and generally coincides with the date that coverage as an active employee is terminated.
- The effective date of coverage for a new retiree (and eligible dependents) who was not covered as an active employee in the SHBP or SEHBP is the date of retirement.
- The effective date of coverage for members who retire from a board of education, vocational/technical school, or special services commission, participate in their employer's health plan (not SEHBP) and enroll in the SEHBP Retired Group when they enroll in Medicare, will be the date that their Medicare Parts A and B are effective.
- The effective date of coverage for a surviving spouse or partner and eligible children is the date the coverage terminates as a dependent due to the death of the retiree.

End of Coverage

Your coverage under a Retiree Dental Plan terminates if:

- You formally request termination in writing, or by canceling your coverage online through Benefitsolver;
- Your retirement is canceled;
- Your pension allowance is suspended;
- You do not pay your required premiums;
- Your former employer withdraws from the SHBP and/or SEHBP (this may not apply to certain retirees of education, police, and fire employers);
- Your Medicare coverage ends;
- You die (see the "Survivor Coverage" section);
- The SHBP and/or SEHBP is discontinued; or
- You become ineligible for Retired Group medical coverage through the SHBP or SEHBP.

Coverage for your dependents will end if:

- Your coverage ceases for any of the reasons previously listed;
- Your dependent is no longer eligible for coverage (divorce of a spouse; dissolution of a civil union or same-sex domestic partnership; child turns age 26 unless the dependent child qualifies for continuance of coverage due to disability);
- Your enrolled dependent enters the Armed Forces; or
- Your dependent becomes enrolled on their own through the SHBP or SEHBP in a dental plan as a subscriber.

In general, once Retiree Dental Plans coverage is terminated, it will not be reinstated.

Survivor Coverage

If you, the retired member, predecease your covered dependents, your surviving dependents may be eligible for continued coverage in a Retiree Dental Plan. Surviving dependents are generally notified of their rights to continued coverage at the time the NJDPB is notified of the death of the retiree; however, they may contact the NJDPB Office of Client Services for enrollment instructions or for more information. It is imperative that survivors notify the NJDPB as soon as possible after your death because their dependent coverage terminates the 1st of the month following the date of your death.

EXTENSION OF COVERAGE PROVISIONS

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

If Eligibility Ends While Undergoing Treatment

If your coverage is terminated due to your voluntary termination from the plan or failure to pay the required premium, there is no extension of ongoing treatment for you or your dependents.

If you die, and your dependents do not elect to continue Retiree Dental Plans coverage under their own account and are undergoing treatment, 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; or
- 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.

COORDINATION OF BENEFITS WITH OTHER INSURANCE PLANS

There is no coordination of benefits between two SHBP/SEHBP dental plans because no member is eligible for coverage under more than one dental plan. You and your spouse/partner may be covered under a dental plan as an employee/retiree or as a dependent but not as both.

If you and your dependents are covered under a dental plan other than through the SHBP/SEHBP, 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 basic determination of which plan provides primary coverage is as follows:

- The retiree's primary dental coverage is provided by the Retiree Dental Plans. If the retiree is also employed and has dental coverage through another employer other than the State, then the dental coverage provided by the employer is primary to the Retiree Dental Plans.
- 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 and any dependents also covered by your spouse/partner is through the dental plan offered by his or her employer.
- Coverage through a parent's active employment is primary over coverage through a retiree for children.
- 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 plan will determine the order of benefits.
- In the case of a separation or divorce, 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.

THE RETIREE DENTAL PLAN ORGANIZATION

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. The Employee Dental Plans include a single DPO option which offers two types of plans – Dental Centers 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)** consists 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. 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 DPO and participating dentists from your benefits administrator. 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 Retiree Dental Plans, and will accept you as a new patient.
- If you choose a dentist, you should also check with the dentist to make sure that they plan to stay in the DPO. If the dentist leaves, you will have to select another dentist who participates with that DPO.
- You should also 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 (the Dental Expense Plans (DEPs)).

Retiree DPO Reimbursement Tiers

It is important for plan members to go for regular dental checkups, not only for their own health, but also because treatment in later years could be more expensive for them if they do not. To protect the plans and enrolled members against the effect of retirees joining who have gone years without any dental treatment, the plans have three benefit tiers — Tiers 1, 2, and 3. If you enroll in a Retiree Dental Plan within 60 days of leaving another group dental program in which you were enrolled for a minimum of 12 months, you will be enrolled in the highest reimbursement tier — Tier 3. If you were not covered in a group dental program within 60 days of enrolling in a Retiree Dental Plan — or were enrolled in a group dental program for less than 12 months — you will be enrolled in Tier 1. After one year of coverage in Tier 1, you will move to Tier 2. After another year, you will be moved to Tier 3. Once enrolled in Tier 3, you will remain in that tier for as long as you continue to be enrolled.

The types of services covered are based on the dental tier in which you are currently enrolled:

- **Tier 1** - Diagnostic and Preventive Services Only
- **Tier 2** - Includes Tier 1 Services Plus Restorative Services
- **Tier 3** - Includes Full Retiree DPO Plan Design

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		
The following are covered services under Dental Tiers 1, 2, and 3.		
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 — Periapical — 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		
The following are covered services under Dental Tiers 1, 2, and 3.		
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 Preventative 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 following are covered services under Dental Tiers 2 and 3 only.		
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	$15
D2150	Amalgam — Two Surfaces — Primary or Permanent	$20
D2160	Amalgam — Three Surfaces — Primary or Permanent	$25
D2161	Amalgam — Four or More Surfaces — Primary or Permanent	$30
Resin Restorations		
D2330	Resin-Based Composite — One Surface — Anterior	$25
D2331	Resin-Based Composite — Two Surfaces — Anterior	$30
D2332	Resin-Based Composite — Three Surfaces — Anterior	$35
D2335	Resin-Based Composite — Four or More Surfaces or Involving Incisal Angle — Anterior	$45
D2390	Resin-Based Composite Crown — Anterior	$55
D2391	Resin-Based Composite — One Surface — Posterior	$25
D2392	Resin-Based Composite — Two Surfaces — Posterior	$40
D2393	Resin-Based Composite — Three Surfaces — Posterior	$55
D2394	Resin-Based Composite — Four or More Surfaces — Posterior	$70
Inlay/Onlay Restorations		
D2510	Inlay — Metallic — One Surface	$150
D2520	Inlay — Metallic — Two Surfaces	$150
D2530	Inlay — Metallic — Three or More Surfaces	$150
D2542	Onlay — Metallic — Two Surfaces	$150
D2543	Onlay — Metallic — Three Surfaces	$150
D2544	Onlay — Metallic — Four or More Surfaces	$150
D2610	Inlay — Porcelain/Ceramic — One Surface	$175
D2620	Inlay — Porcelain/Ceramic — Two Surfaces	$175
D2630	Inlay — Porcelain/Ceramic — Three or More Surfaces	$175
D2642	Onlay — Porcelain/Ceramic — Two Surfaces	$175
D2643	Onlay — Porcelain/Ceramic — Three Surfaces	$175
D2644	Onlay — Porcelain/Ceramic — Four or More Surfaces	$175
D2650	Inlay — Resin-Based Composite — One Surface	$160
D2651	Inlay — Resin-Based Composite — Two Surfaces	$160
D2652	Inlay — Resin-Based Composite — Three or More Surfaces	$160
D2662	Onlay — Resin-Based Composite — Two Surfaces	$160
D2663	Onlay — Resin-Based Composite — Three Surfaces	$160
D2664	Onlay — Resin-Based Composite — Four or More Surfaces	$160
Crowns — Single Restorations Only		
D2710	Crown — Resin-Based Composite (Indirect) See **Note**	$175
D2720	Crown — Resin With High Noble Metal	$235
D2721	Crown — Resin With Predominantly Base Metal	$225
D2722	Crown — Resin With Noble Metal	$225
D2740	Crown — Porcelain/Ceramic Substrate	$295
D2750	Crown — Porcelain Fused to High Noble Metal	$340

Codes	Description of Covered Services	Copayments
D2751	Crown — Porcelain Fused to Predominantly Base Metal	$295
D2752	Crown — Porcelain Fused to Noble Metal	$295
D2753	Crown - Porcelain Fused to Titanium and Titanium Alloys	$295
D2780	Crown — 3/4 Cast High Noble Metal	$340
D2781	Crown — 3/4 Cast Predominantly Base Metal	$295
D2790	Crown — Full Cast High Noble Metal	$340
D2791	Crown — Full Cast Predominantly Base Metal	$295
D2792	Crown — Full Cast Noble Metal	$295
D2794	Crown — Titanium and Titanium Alloys	$340
Note: There is no copayment for procedure D2710 when performed in conjunction with a permanent crown on the same tooth.		
Other Restorative Services		
D2910	Recement Inlay, Onlay, or Partial Coverage Restoration	$15
D2915	Recement Cast or Prefabricated Post and Core	$15
D2920	Recement Crown	$15
D2921	Reattachment of Tooth Fragment Incisal Edge or Cusp	$0
D2929	Prefabricated Porcelain/ Ceramic Crown — Primary Tooth	$69
D2930	Prefabricated Stainless Steel Crown — Primary Tooth	$55
D2931	Prefabricated Stainless Steel Crown — Permanent Tooth	$55
D2932	Prefabricated Resin Crown	$55

Codes	Description of Covered Services	Copayments
D2933	Prefabricated Stainless Steel Crown With Resin Window	$55
D2934	Prefabricated Esthetic Coated Stainless Steel Crown — Primary Tooth	$55
D2940	Protective Restoration	$20
D2941	Interim Therapeutic Restoration — Primary Dentition	$0
D2950	Core Buildup, Including any Pins	$45
D2951	Pin Retention — Per Tooth in Addition to Restoration	$15
D2952	Cast Post and Core in Addition to Crown	$60
D2954	Prefabricated Post and Core in Addition to Crown	$60
D2955	Post Removal	$45
D2971	Additional Procedures to Construct New Crown under Existing Partial Denture Framework	$20
D2980	Crown Repair Necessitated by Restorative Material Failure	$15
D2981	Inlay Repair Necessitated by Restorative Material Failure	$15
D2982	Onlay Repair Necessitated by Restorative Material Failure	$15
D2983	Veneer Repair Necessitated by Restorative Material Failure	$15
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	$15
D3000-D3999 IV. Endodontics **The following are covered services under Dental Tier 3 only.**		
Pulp Capping		
D3110	Pulp Capping — Direct — Excluding Final Restoration	$15

Codes	Description of Covered Services	Copayments
D3120	Pulp Capping — Indirect — Excluding Final Restoration	$15
Pulpotomy		
D3220	Therapeutic Pulpotomy — Excluding Final Restoration	$35
D3222	Therapeutic Pulpotomy — Partial Pulpotomy for Apexogenesis — Permanent Tooth With Incomplete Root Development	$35
Endodontic Therapy on Primary Teeth		
D3230	Pulpal Therapy (Resorbable Filling) — Anterior-Primary Tooth — Excluding Final Restoration	$35
D3240	Pulpal Therapy (Resorbable Filling) — Posterior-Primary Tooth — Excluding Final Restoration	$35
Endodontic Therapy		
D3310	Anterior (Excluding Final Restoration)	$150
D3320	Bicuspid (Excluding Final Restoration)	$190
D3330	Molar (Excluding Final Restoration)	$225
Endodontic Retreatment		
D3346	Retreatment of Previous Root Canal Therapy — Anterior	$190
D3347	Retreatment of Previous Root Canal Therapy — Bicuspid	$225
D3348	Retreatment of Previous Root Canal Therapy — Molar	$265
Apexification/Recalcification Procedures		
D3351	Apexification/Recalcification — Initial Visit	$55
D3352	Apexification/Recalcification — Interim Medication Replacement	$55

Codes	Description of Covered Services	Copayments
D3353	Apexification/Recalcification — Final Visit	$55
Apicoectomy/Periapical Services		
D3410	Apicoectomy/Periradicular Surgical — Anterior	$135
D3421	Apicoectomy/Periradicular Surgical — Bicuspid First Root	$135
D3425	Apicoectomy/Periradicular Surgical — Molar First Root	$135
D3426	Apicoectomy/Periradicular Surgical — Each Additional Root	$60
D3427	Periradicular Surgical — Without Apicoectomy	$135
D3430	Retrograde Filling — Per Root	$35
D3450	Root Amputation — Per Root	$60
Other Endodontic Procedures		
D3910	Surgical Procedure for Isolation of Tooth With Rubber Dam	$15
D3920	Hemisection (Including any Root Removal) — Not Including Root Canal Therapy	$80
D4000-D4999 V. Periodontics **The following are covered services under Dental Tier 3 only.**		
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	$135
D4211	Gingivectomy or Gingivoplasty — One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$90
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	$160
D4241	Gingival Flap Procedure including Root Planing — One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$90
D4245	Apically Positioned Flap	$130
D4249	Clinical Crown Lengthening — Hard Tissue	$160
D4260	Osseous Surgery (Including Flap Entry and Closure) — Four or more Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$265
D4261	Osseous Surgery (Including Flap Entry and Closure) — One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$150
D4263	Bone Replacement Graft — Retained Natural Tooth — First Site in Quadrant	$135
D4264	Bone Replacement Graft — Retained Natural Tooth — Each Additional Site in Quadrant	$75
D4266	Guided Tissue Regeneration — Resorbable Barrier per Site	$120
D4267	Guided Tissue Regeneration — Non-resorbable Barrier per Site (Includes Membrane Removal)	$135
D4270	Pedicle Soft Tissue Graft Procedure	$235
D4273	Autogenous Connective Tissue Graft Procedures (Including Donor and Recipient Surgical Sites) — First Tooth, Implant, or Edentulous Tooth Position in Graft	$250
D4274	Mesial/Distal Procedure — Single Tooth (When not Performed in Conjunction With Surgical Procedures in the same Anatomical Area)	$100
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site and Donor Material) — First Tooth, Implant, or Edentulous Tooth Position in Graft	$235
D4276	Combined Connective Tissue and Double Pedicle Graft — Per Tooth	$235
D4277	Free Soft Tissue Graft Procedure (Including Recipient and Donor Surgical Sites) — First Tooth, Implant, or Edentulous Tooth Position in a Graft	$70
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

Codes	Description of Covered Services	Copayments
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	$138
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	$129
Non-Surgical Periodontal Services		
D4320	Provisional Splinting — Intracoronal	$25
D4321	Provisional Splinting — Extracoronal	$25
D4341	Periodontal Scaling and Root Planing — Four or More Teeth per Quadrant	$70
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	$20
D4355	Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis	$40
Other Periodontal Services		
D4910	Periodontal Maintenance	$40
D4920	Unscheduled Dressing Change (By someone other than Treating Dentist)	$15

Codes	Description of Covered Services	Copayments
D5000-D5899 VI. Prosthodontics (Removable)		
The following are covered services under Dental Tier 3 only.		
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	$340
D5120	Complete Denture — Mandibular	$340
D5130	Immediate Denture — Maxillary	$370
D5140	Immediate Denture — Mandibular	$370
Partial Dentures *Including Routine Post Delivery Care*		
D5211	Maxillary Partial Denture — Resin Base (Including any Conventional Clasps, Rests, and Teeth)	$370
D5212	Mandibular Partial Denture — Resin Base (Including any Conventional Clasps, Rests, and Teeth)	$370
D5213	Maxillary Partial Denture — Cast Metal Framework w/ Resin Denture Bases (Including Retentive/Clasping Materials, Rests, and Teeth)	$405
D5214	Mandibular Partial Denture — Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests, and Teeth)	$405
D5221	Immediate Maxillary Partial Denture — Resin Base (Including Retentive/Clasping Materials, Rests, and Teeth)	$426

Codes	Description of Covered Services	Copayments
D5222	Immediate Mandibular Partial Denture — Resin Base (Including Retentive/Clasping Materials, Rests, and Teeth)	$426
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	$466
D5224	Immediate Mandibular Partial Denture — Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests, and Teeth)	$466
D5225	Maxillary Partial Denture — Flexible Base (Including any Clasps, Rests, and Teeth)	$445
D5226	Mandibular Partial Denture — Flexible Base (Including any Clasps, Rests, and Teeth)	$445
D5281	Removable Unilateral Partial Denture — One Piece Cast Metal (Including Clasps and Teeth)	$205
D5284	Removable Unilateral Partial Denture - One Piece Flexible Base (Including Clasps and teeth) - Per Quadrant	$223
D5286	Removable Unilateral Partial Denture - One Piece Resin (Including Clasps and teeth) - Per Quadrant	$185
Adjustments to Removable Prostheses		
D5410	Adjust Complete Denture — Maxillary	$15

Codes	Description of Covered Services	Copayments
D5411	Adjust Complete Denture — Mandibular	$15
D5421	Adjust Partial Denture — Maxillary	$15
D5422	Adjust Partial Denture — Mandibular	$15
Repairs to Complete Dentures		
D5510	Repair Broken Complete Denture Base	$55
D5520	Replace Missing or Broken Teeth — Complete Denture — Each Tooth	$55
Repairs to Partial Dentures		
D5610	Repair Resin Denture Base	$55
D5620	Repair Cast Framework	$55
D5630	Repair or Replace Broken Clasp — Per Tooth	$55
D5640	Replace Broken Teeth — Per Tooth	$55
D5650	Add Tooth to Existing Partial Denture	$55
D5660	Add Clasp to Existing Partial Denture — Per Tooth	$55

Codes	Description of Covered Services	Copayments
Denture Rebase Procedures		
D5710	Rebase Complete Maxillary Denture	$130
D5711	Rebase Complete Mandibular Denture	$130
D5720	Rebase Maxillary Partial Denture	$130
D5721	Rebase Mandibular Partial Denture	$130
Denture Reline Procedures		
D5730	Reline Complete Maxillary Denture — Chairside	$60
D5731	Reline Complete Mandibular Denture — Chairside	$60
D5740	Reline Maxillary Partial Denture — Chairside	$60
D5741	Reline Mandibular Partial Denture — Chairside	$60
D5750	Reline Complete Maxillary Denture — (Lab Process)	$60
D5751	Reline Complete Mandibular Denture — (Lab Process)	$60
D5760	Reline Maxillary Partial Denture — (Lab Process)	$60
D5761	Reline Mandibular Partial Denture — (Lab Process)	$60
Other Removable Prosthetic Services		
D5810	Interim Complete Denture (Maxillary)	$75
D5811	Interim Complete Denture (Mandibular)	$75
D5820	Interim Partial Denture (Maxillary)	$60
D5821	Interim Partial Denture (Mandibular)	$60
D5850	Tissue Conditioning (Maxillary)	$55

Codes	Description of Covered Services	Copayments
D5851	Tissue Conditioning (Mandibular)	$55
D6200-D6999 VII. Prosthodontics, Fixed **The following are covered services under Dental Tier 3 only.**		
Fixed Partial Denture Pontics		
D6097	Abutment Supported Crown - Porcelain Fused to Titanium and Titanium Alloys	$295
D6210	Pontic — Cast High Noble Metal	$340
D6211	Pontic — Cast Predominantly Base Metal	$295
D6212	Pontic — Cast Noble Metal	$295
D6214	Pontic — Titanium	$340
D6240	Pontic — Porcelain Fused to High Noble Metal	$340
D6241	Pontic — Porcelain Fused to Predominantly Base Metal	$295
D6242	Pontic — Porcelain Fused to Noble Metal	$295
D6243	Pontic - Porcelain Fused to Titanium and Titanium Alloys	$295
D6245	Pontic — Porcelain/Ceramic	$295
D6250	Pontic — Resin With High Noble Metal	$225
D6251	Pontic — Resin With Predominantly Base Metal	$225
D6252	Pontic — Resin With Noble Metal	$225
Fixed Partial Denture Retainers — Inlays/Onlays		
D6545	Retainer — Cast Metal for Resin Bonded Fixed Prosthesis	$150
D6549	Resin Retainer — For Resin Bonded Fixed Prosthesis	$75

Codes	Description of Covered Services	Copayments
D6602	Inlay — Cast High Noble Metal — Two Surfaces	$265
D6603	Inlay — Cast High Noble Metal — Three or More Surfaces	$265
D6604	Inlay — Cast Predominantly Base Metal — Two Surfaces	$160
D6605	Inlay — Cast Predominantly Base Metal — Three or More Surfaces	$160
D6606	Inlay — Cast Noble Metal — Two Surfaces	$230
D6607	Retainer Inlay — Cast Noble Metal — Three or More Surfaces	$230
D6610	Retainer Onlay — Cast High Noble Metal — Two Surfaces	$275
D6611	Retainer Onlay — Cast High Noble Metal — Three or More Surfaces	$275
D6612	Retainer Onlay — Cast Predominantly Base Metal — Two Surfaces	$160
D6613	Retainer Onlay — Cast Predominantly Base Metal — Three or More Surfaces	$160
D6614	Retainer Onlay — Cast Noble Metal — Two Surfaces	$265
D6615	Retainer Onlay — Cast Noble Metal — Three or More Surfaces	$265
D6624	Retainer Inlay — Titanium	$265
D6634	Retainer Onlay — Titanium	$275
Fixed Partial Denture Retainers — Crown		
D6720	Retainer Crown — Resin With High Noble Metal	$225
D6721	Retainer Crown — Resin With Predominantly Base Metal	$225
D6722	Retainer Crown — Resin With Noble Metal	$225
D6740	Retainer Crown — Porcelain/ Ceramic	$295
D6750	Retainer Crown — Porcelain Fused to High Noble Metal	$340
D6751	Retainer Crown — Porcelain Fused to Predominantly Base Metal	$295
D6752	Retainer Crown — Porcelain Fused to Noble Metal	$295
D6753	Retainer Crown - Porcelain Fused to Titanium and Titanium Alloys	$295
D6780	Retainer Crown — 3/4 Cast High Noble Metal	$340
D6781	Retainer Crown — 3/4 Cast Predominantly Base Metal	$295
D6782	Retainer Crown — 3/4 Cast Noble Metal	$295
D6783	Retainer Crown — 3/4 Porcelain/Ceramic	$295
D6784	Retainer Crown 3/4- Titanium and Titanium Alloys	$295
D6790	Retainer Crown — Full Cast High Noble Metal	$340
D6791	Retainer Crown — Full Cast Predominantly Base Metal	$295
D6792	Retainer Crown — Full Cast Noble Metal	$295
D6794	Retainer Crown — Titanium	$340
Other Fixed Partial Denture Services		
D6930	Recement Fixed Partial Denture	$25
D6980	Fixed Partial Denture Repair Necessitated by Restorative Material Failure	$45

Codes	Description of Covered Services	Copayments
D7000-D7999 VIII. Oral and Maxillofacial Surgery		
The following are covered services under Dental Tier 3 only.		
Extractions *Includes local anesthesia, suturing, if needed, and routine post-operative care.*		
D7111	Extraction — Coronal Remnants — Deciduous Tooth	$20
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	$35
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	$45
D7220	Removal of Impacted Tooth — Soft Tissue	$80
D7230	Removal of Impacted Tooth — Partially Bony	$80
D7240	Removal of Impacted Tooth — Completely Bony	$100
D7241	Removal of Impacted Tooth — Completely Bony With Complications	$100

Codes	Description of Covered Services	Copayments
Surgical Extractions *Includes local anesthesia, suturing, if needed, and routine post-operative care.*		
D7250	Removal of Residual Tooth Roots — Cutting Procedure	$45
D7251	Coronectomy — Intentional Partial Tooth Removal	$48
Other Surgical Procedures		
D7260	Oroantral Fistula Closure	$150
D7261	Primary Closure of a Sinus Perforation	$150
D7270	Tooth Reimplantation/ Stabilization	$90
D7280	Exposure of an Unerupted Tooth	$90
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$70
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$25
D7285	Biopsy of Oral Tissue — Hard (Bone, Tooth)	$95
D7286	Biopsy of Oral Tissue — Soft	$40
D7287	Exfoliative Cytology — Sample Collection	$13
D7291	Transseptal Fiberotomy Supra Crestal Fiberotomy — By Report	$35

Codes	Description of Covered Services	Copayments
Alveoloplasty — Surgical Preparation of the Ridge for Dentures		
D7310	Alveoloplasty in Conjunction Wwith 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	$45
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	$25
D7320	Alveoloplasty not in Conjunction With Extractions — Per Quadrant	$55
D7321	Alveoloplasty not in Conjunction with Extractions — One to Three Teeth or Tooth Spaces per Quadrant	$35
Removal of Cysts, Tumors, and Neoplasms		
D7450	Removal of Benign Odontogenic Cyst or Tumor — Lesion up to 1.25 cm Diameter	$90
D7451	Removal of Benign Odontogenic Cyst or Tumor — Lesion Greater than 1.25 cm Diameter	$90
D7460	Removal of Benign Non-Odontogenic Cyst or Tumor — Lesion up to 1.25 cm Diameter	$90

Codes	Description of Covered Services	Copayments
D7461	Removal of Benign Non-Odontogenic Cyst or Tumor — Lesion Greater than 1.25 cm Diameter	$90
Excision of Bone Tissue		
D7471	Removal of Lateral Exostosis — Maxilla or Mandible	$135
D7472	Removal Torus Palatinus	$135
D7473	Removal Torus Mandibularis	$135
D7485	Reduction of Osseous Tuberosity	$135
Surgical Incision		
D7510	Incision and Drainage of Abscess — Intraoral — Soft Tissue	$40
D7511	Incision and Drainage of Abscess — Intraoral — Soft Tissue — Complicated (Includes Drainage of Multiple Facial Spaces)	$45
D7520	Incision and Drainage of Abscess — Extraoral — Soft Tissue	$55
D7521	Incision and Drainage of Abscess — Extraoral — Soft Tissue — Complicated (Includes Drainage of Multiple Facial Spaces)	$60
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	$100

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	$90
D7963	Frenuloplasty	$100
D7970	Excision of Hyperplastic Tissue — Per Arch	$90
D7971	Excision of Pericoronal Gingiva Removal of Inflammatory or Hypertrophied Tissues Surrounding Partially Erupted/ Impacted Teeth	$45
D7972	Surgical Reduction of Fibrous Tuberosity	$90
D9000-D9999 IX. Adjunctive General Services **The following are covered services under Dental Tier 3 only.**		
Miscellaneous Services		
D9110	Palliative (Emergency) Treatment of Dental Pain — Minor Procedure	$15
D9211	Regional Block Anesthesia	$5
D9212	Trigeminal Division Block Anesthesia	$5
D9215	Local Anesthesia	$5
D9219	Evaluation for Deep Sedation or General Anesthesia	$0
D9223	Deep Sedation/General Anesthesia — Each 15-Minute Increment	$30
D9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	$5
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia — Each 15-Minute Increment	$30
D9310	Consultation (Diagnostic Service Provided by a Dentist or Physician other than Practitioner Providing Treatment)	$5
D9311	Treating Dentist Consults with a Medical Health Care Professional Concerning Medical Issues that May Affect Patient's Planned Dental Treatment	$5
D9430	Office Visit Observation	$0
D9440	Office Visit After Hours	$0
D9610	Therapeutic Drug Injection — By Report	$5
D9612	Therapeutic Parenteral Drug, Two or more Administrations Different Medications	$0
D9630	Drugs or Medicaments Dispensed in the Office for Home Use	$5
D9910	Application of Desensitizing Medication	$5
D9930	Treat Complications — By Report	$5
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	$60
D9942	Repair and/or Reline of Occlusal Guard	$35
D9943	Occlusal Guard Adjustment	$8
D9951	Occlusal Adjustment — Limited	$5
D9952	Occlusal Adjustment — Complete	$90
D9997	Dental Case Management - Patients With Special Health Care Needs	$0

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.
- 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.
- Orthodontics.
- Services and supplies provided in connection with treatment or care that is not covered under the plan.

SHBP RETIREE DENTAL EXPENSE PLANS

The SHBP Retiree Dental Expense Plans (DEPs) are Preferred Provider Organization (PPO) plans that will reimburse you for a portion of the expenses you, and your enrolled eligible dependents, incur 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.

Deductibles

Diagnostic and preventive services are not subject to an annual deductible amount. For all other services an annual deductible amount of $50 of covered expenses that you or each of your dependents incur in a calendar year is not eligible for reimbursement. However, if there are three or more members of your family enrolled in the plan, no additional deductibles are charged for the calendar year after a total of $150 in eligible expenses. Charges incurred in a dental plan prior to your enrollment in this plan will not count towards your annual deductible.

After any applicable annual deductible is satisfied, you are reimbursed a percentage of the negotiated, discounted fee for in-network services or reasonable and customary allowance for out-of-network services that are covered under the plan.

Discounted Fee-for-Service Network

It is recommended that you take advantage of a special network of participating dental providers who discount their fees for services. When you use 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 most cases the participating dental provider will submit the claims directly for you, eliminating

the necessity of your filing claim forms. Out-of-network dentists are not required to file claims on your behalf, and you may be responsible for submitting a claim form directly to Aetna or Horizon. In some cases, an out-of-network dentist may ask you to pay your bill in full and ask you to submit the claim for reimbursement. To find out if your provider participates in the discounted network, contact the appropriate plan:

- **Aetna**: Call 1-877-STATENJ (1-877-782-8365) or visit Aetna's website at ***www.aetna.com/docfind/custom/statenj***
- **Horizon**: Call 1-833-597-SHBP (1-833-597-7427) or visit Horizon's website at ***www.horizonblue.com/shbp***

Reasonable and Customary Allowance

The reasonable and customary allowance only applies to out-of-network services. When utilizing an out-of-network provider, the plan covers only that part of a provider's fee for a service or supply that is reasonable and customary. Generally speaking, a fee charged by your dentist, or by any other provider of services or supplies, is considered reasonable and customary if it doesn't exceed the prevailing fee charged for the same service or supply by similar providers in the same geographic area. If your dentist charges more than the reasonable and customary allowance, you are responsible for the amount above the reasonable and customary allowance unless a participating dental provider is used.

Reimbursement

Once members meet their $50 annual deductible (if applicable), the costs of all other eligible services for that person are reimbursed at a percentage of the reasonable and customary allowance for the service.

Annual Benefit Maximum

The most the SHBP DEP plans will pay for any one person in any calendar year is $1,500. This maximum applies to all eligible services.

PLAN DESIGN

Three Tier Benefit Design

The SHBP Retiree DEPs feature three benefit tiers (see the "SHBP Retiree Dental Expense Plan Reimbursement Tiers" chart). Your initial benefit tier depends upon whether you were covered under a group dental plan just prior to your enrollment:

- If you, the retiree, were covered under a group dental plan for at least one year within 60 days of joining this plan, you and your eligible dependents will be enrolled at the highest level of benefits — Tier 3. Specific information concerning the 12-month dental plan enrollment must be provided on your enrollment application.
- If you, the retiree, were not covered under a group dental plan for at least one year within 60 days of joining this plan, you and your eligible dependents will be enrolled at the lowest level of reimbursement — Tier 1. Each year you remain a member of the plan, your reimbursement benefit will rise to a higher tier until you are at the top level of benefits (Tier 3).

COVERED SERVICES

The SHBP Retiree DEP covers preventive care, basic services, and major restorative services at different levels. The deductible is waived for preventive care. The Retiree DEP does not reimburse for any orthodontic services. A general description of each category of service follows.

Preventive Care

Preventive care consists of diagnostic and preventive services that are precautionary services intended to maintain oral health and reduce the effects of tooth decay or gum disease that could lead to an increased need for more costly restorative services. They include the following:

- Oral evaluations (includes comprehensive, periodic, and problem-focused oral evaluations);
- X-rays (limitations apply - see the "DEP Services Eligible for Reimbursement" section);
- Prophylaxis (cleaning of the teeth, including the removal of plaque, calculus, and stains from tooth structures, limitations apply - see the "DEP Services Eligible for Reimbursement" section);
- Fluoride Treatments (topical application of fluoride for children under age 19); and
- Laboratory and other dental diagnostic tests.

Basic Services

Basic services include:

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

SHBP RETIREE DENTAL EXPENSE PLAN REIMBURSEMENT TIERS

	Annual Deductible	Coinsurance		Maximum Annual Benefit
Tier 1	$50 per person, but not more than $150 total; waived for Preventive Care	**IN-NETWORK** 80% - Preventive & Diagnostic Care 50% - Basic Restorative 30% - Major Restorative	**OUT-OF-NETWORK** 70% - Preventive & Diagnostic Care 50% - Basic Restorative 20% - Major Restorative	$1,500 per person
Tier 2	$50 per person, but not more than $150 total; waived for Preventive Care	**IN-NETWORK** 90% - Preventive & Diagnostic Care 60% - Basic Restorative 40% - Major Restorative	**OUT-OF-NETWORK** 80% - Preventive & Diagnostic Care 50% - Basic Restorative 30% - Major Restorative	$1,500 per person
Tier 3	$50 per person, but not more than $150 total; waived for Preventive Care	**IN-NETWORK** 100% - Preventive Care 70% - Basic Restorative 50% - Major Restorative	**OUT-OF-NETWORK** 90% - Preventive & Diagnostic Care 50% - Basic Restorative 40% - Major Restorative	$1,500 per person

Major Restorative Services

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.

Other Major Restorative services include:

- 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.

Note: Orthodontic services are not covered under the SHBP Retiree DEP.

ADDITIONAL PROVISIONS OF THE PLAN

How Payments Are Made

If you use a participating dental network provider, payments are made directly to the provider less any applicable deductible or appropriate coinsurance based on the discounted fee (see the "Deductibles" section).

If you use a non-participating provider, the provider may ask you to pay for the service in advance. If the provider's office asks you to pre-pay for the services, it will be your responsibility to submit the claim to Aetna or Horizon for reimbursement. The retiree may, however, authorize Aetna or Horizon to send the reimbursement directly to the dental provider by completing the appropriate section of the claim form. Additionally, whenever a law or court order requires the payment of dental expense benefits under the plan to be made to a person or facility other than the retiree, 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 or Horizon 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, 2024, you would have until April 30, 2026 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.

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; and
- Charge for each service.

Predetermination of Benefits/ Pretreatment Estimates

A predetermination of benefits (Aetna terminology) and a pretreatment estimate (Horizon terminology) are voluntary processes that allow you to know what services are covered and the estimated payment based on the information provided 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 a predetermination of benefits or a pretreatment estimate depending on your plan.

This feature of the SHBP Retiree DEP ensures that both you and the dentist will know in advance what part of the dentist's charges the plan estimates it will cover. If possible, treatment should be completed within 90 days of receiving the approved predetermination of benefits or pretreatment estimate.

The predetermination of benefits/pretreatment estimate provision of the SHBP Retiree DEP is important, because under the alternative procedures provision (see the "Alternative Procedures" section), Aetna and Horizon have 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/Pretreatment Estimates Work — Your dentist submits a treatment plan and Aetna or Horizon estimates the amount the SHBP Retiree DEP will pay and informs you and the dentist of its payment decision. You and your dentist should discuss the payment before the work is started.

Predetermination of benefits and pretreatment estimates will help you avoid surprises. Most dentists are familiar with these procedures; if not, they should call Aetna at 1-877-STATENJ (1-877-782-8365) or Horizon at 1-833-597-SHBP (1-833-597-7427). If your dentist submits a treatment plan for predetermination of benefits or pretreatment estimates and then alters the course of treatment, Aetna or Horizon will adjust its payments accordingly. If the dentist makes a major change in the treatment plan, they 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 so long as the result 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.

SHBP DEP SERVICES ELIGIBLE FOR REIMBURSEMENT

See the Glossary for a definition of terms.

- Oral evaluations covered at 80, 90, or 100 percent in-network, or at 70, 80, or 90 percent out-of-network depending on your benefit tier (limited to twice in a calendar year). Emergency or limited oral evaluations are covered, limited to one evaluation per patient, per year. Periodontal maintenance evaluations are included as oral evaluations.
- 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 in a 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 the removal of plaque, calculus, and stains from tooth structures (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.
- 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).

- Periodontics procedures (reimbursement for periodontal surgical procedures, usually provided for a specific quadrant, is limited to one surgical-type procedure, per quadrant every 36 months). Reimbursement for periodontal scaling and root planing procedures per specific quadrant is limited to one procedure in a 12-month interval.
- Periodontal surgical procedures, usually provided for specific quadrants, are subject to a reduced reimbursement when the number of diseased teeth in a quadrant are less than four. Additional reduction in benefits may apply, when multiple types of procedures are provided in the same quadrant, at the same appointment.
- 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.
- Routine extractions of teeth.
- Endodontic services, such as pulpotomy and root canal therapy.
- Space maintainers (other than for orthodontic treatment).
- Oral surgical procedures considered dental in nature — such as, but not limited to: surgical extractions, treatment of fractures, removal of lesions of the mouth, and alveolectomy.
- Apicoectomy.
- General anesthesia (including conscious sedation coverage) when medically necessary and in connection with covered oral and periodontal surgical procedures.

SHBP DEP SERVICES NOT ELIGIBLE FOR REIMBURSEMENT

- Any orthodontic service.
- 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.
- Myofunctional therapy.
- A charge in connection with appliances, restorations, or procedures needed to alter vertical dimensions or restore occlusion, or for the purpose of splinting or correcting attrition, abrasion, or erosion.
- Crowns, inlays, or onlays if used in splinting procedures during periodontal treatment.
- Charges for sterilization or asepsis.
- 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 not reasonably necessary 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 plan; except that a procedure will not have been considered to have started with an oral prophylaxis or a diagnostic procedure.
- Any service or supply which is furnished or made available to a patient or financed by federal, State, or local government, including Medicare or a like-plan, Workers' Compensation law or a similar law, any automobile no-fault law, or any other plan or law under which the patient is or could be covered, whether or not the patient makes any claim or receives compensation under it.
- Any charge incurred after the patient is no longer covered, except in the case of an extension of coverage (see the "Extension of Coverage Provisions-section).
- Any charge for a service that is more than the reasonable and customary allowance (see the "Reasonable and Customary Allowance" section).
- Any charge for a service rendered by a member of the patient's immediate family (including you, your spouse/partner, your child, brother, sister, or parent of you or your spouse/partner).
- Any service or supply other than those specifically covered under this program.
- Services and supplies provided in connection with treatment or care that is not covered under the plan.

SEHBP DENTAL EXPENSE PLANS AND DENTAL EXPENSE PLANS PLUS

The SEHBP Retiree Dental Expense Plans are Preferred Provider Organization (PPO) plans that will reimburse you for a portion of the expenses you and your enrolled eligible dependents incur 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.

Deductibles

Diagnostic, preventive and orthodontic services (DEP Plus only) are not subject to an annual deductible amount. For all other services an annual deductible applies as follows:

- Tiers 1–3: A $50 deductible per person, but not more than $150 total.
- Tier 4 (DEP Plus only): A $50 deductible per person, but not more than $100 total.

Charges incurred in a dental plan prior to your enrollment in this plan will not count towards your annual deductible. After any applicable annual deductible is satisfied, you are reimbursed a percentage of the negotiated, discounted fee for in-network services or reasonable and customary allowance for out-of-network services that are covered under the plan.

Discounted Fee-for-Service Network

It is recommended that you take advantage of a special network of participating dental providers who discount their fees for services. When you use 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 most cases the participating dental provider will submit the claims directly for you, eliminating the necessity of your filing claim forms. Out-of-network dentists are not required to file claims on your behalf, and you may be responsible for submitting a claim form directly to Aetna or Horizon. In some cases, an out-of- network dentist may ask you to pay your bill in full and ask you to submit the claim for reimbursement. To find out if your provider participates in the discounted network, contact the appropriate plan:

- **Aetna**: Call 1-877-STATENJ (1-877-782-8365) or visit Aetna's website at ***www.aetna.com/docfind/custom/statenj***
- **Horizon**: Call 1-833-597-SHBP (1-833-597-7427) or visit Horizon's website at ***www.horizonblue.com/shbp***

Reasonable and Customary Allowance

The reasonable and customary allowance only applies to out-of-network services. When utilizing an out-of-network provider, the plan covers only that part of a provider's fee for a service or supply that is reasonable and customary. Generally speaking, a fee charged by your dentist, or by any other provider of services or supplies, is considered reasonable and customary if it doesn't exceed the prevailing fee charged for the same service or supply by similar providers in the same geographic area. If your dentist charges more than the reasonable and customary allowance, you are responsible for the amount above the reasonable and customary allowance unless a participating dental provider is used.

Reimbursement

Once members meet their $50 annual deductible (if applicable), the costs of all other eligible services for that person are reimbursed at a percentage of the reasonable and customary allowance for the service.

Annual Benefit Maximum

The most the SEHBP Retiree Dental Expense Plans 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 (DEP Plus only).

PLAN DESIGN

Dental Expense Plan – Three Tier Benefit Design

The SEHBP Retiree DEP features three benefit tiers (see the "SEHBP Retiree Dental Expense Plan/Retiree Dental Expense Plan Plus Reimbursement Tiers" chart). Your initial benefit tier depends upon whether you were covered under a group dental plan just prior to your enrollment.

- If you, the retiree, were covered under a group dental plan for at least one year within 60 days of joining this plan, you and your eligible dependents will be enrolled at the highest level of benefits – Tier 3. Specific information concerning the 12- month dental plan enrollment must be provided on your enrollment application.
- If you, the retiree, were not covered under a group dental plan for at least one year within 60 days of joining this plan, you and your eligible dependents will be enrolled at the lowest level of reimbursement – Tier 1. Each year you remain a member of the plan your reimbursement benefit will rise to a higher tier until you are at the top level of benefits (Tier 3).

Dental Expense Plan Plus - Four Tier Benefit Design

The SEHBP Retiree DEP Plus features four benefit tiers (see the "SEHBP Retiree Dental Expense Plan/ Retiree Dental Expense Plan Plus Reimbursement Tiers" chart). Your initial benefit tier depends upon whether you were covered under a group dental plan just prior to your enrollment:

If you, the retiree, were covered under a group dental plan for at least one year within 60 days of joining this plan, you and your eligible dependents will be enrolled at the highest level of benefits – Tier 4. Specific information concerning the 12-month dental plan enrollment must be provided on your enrollment application.

If you, the retiree, were not covered under a group dental plan for at least one year within 60 days of joining this plan, you and your eligible dependents will be enrolled at the lowest level of reimbursement – Tier 1. Each year you remain a member of the plan your reimbursement benefit will rise to a higher tier until you are at the top level of benefits (Tier 4).

COVERED SERVICES

The SEHBP Retiree DEP Plans cover preventive care, basic services, and major restorative services at different levels. The SEHBP Retiree DEP Plus also covers reimbursement for orthodontic services for those under the age of 19.

Preventive Care

Preventive care consists of diagnostic and preventive services that are precautionary services intended to maintain oral health and reduce the effects of tooth decay or gum disease that could lead to an increased need for more costly restorative services. They include the following:

- Oral evaluations (includes comprehensive, periodic, and problem-focused oral evaluations);
- X-rays (limitations apply - see the "DEP Services Eligible for Reimbursement" section);
- Prophylaxis (cleaning of the teeth, including the removal of plaque, calculus, and stains from tooth structures, limitations apply - see the "DEP Services Eligible for Reimbursement" section);
- Fluoride Treatments (topical application of fluoride for children under age 19); and
- Laboratory and other dental diagnostic tests.

Basic Services

Basic services include:

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

Major Restorative Services

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.

Other Major Restorative services include:

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

Note: Orthodontic Services are only covered under the SEHBP Retiree DEP Plus plan.

ADDITIONAL PROVISIONS OF THE PLAN

How Payments are Made

If you use a participating dental network provider, payments are made directly to the provider less any applicable deductible or appropriate coinsurance based on the discounted fee (see the "Deductibles" section).

If you use a non-participating provider, the provider may ask you to pay for the service in advance. If the provider's office asks you to pre-pay for the services, it will be your responsibility to submit the claim to Aetna or Horizon for reimbursement. The retiree may, however, authorize Aetna or Horizon to send the reimbursement directly to the dental provider by completing the appropriate section of the claim form. Additionally, whenever a law or court order requires the payment of dental expense benefits under the plan to be made to a person or facility other than the retiree, the payment will be made to that person or facility upon proper notification (letter and a copy of the order/law).

SEHBP RETIREE DENTAL EXPENSE PLAN/DENTAL EXPENSE PLAN PLUS REIMBURSEMENT TIERS

	Annual Deductible	Coinsurance		Maximum Annual Benefit
Tier 1	$50 per person, but not more than $150 total; waived for Preventive Care and Orthodontic Service	**IN-NETWORK** 80% - Preventive & Diagnostic Care 50% - Basic Restorative 30% - Major Restorative	**OUT-OF-NETWORK** 70% - Preventive & Diagnostic Care 50% - Basic Restorative 20% - Major Restorative	In-network out-of-pocket maximum is $3,000, out-of-network maximum is $2,000. Total out-of-pocket costs will not exceed $3,000 combined for in- and out-of-network services.
Tier 2	$50 per person, but not more than $150 total; waived for Preventive Care and Orthodontic Service	**IN-NETWORK** 90% - Preventive & Diagnostic Care 60% - Basic Restorative 40% - Major Restorative	**OUT-OF-NETWORK** 80% - Preventive & Diagnostic Care 50% - Basic Restorative 30% - Major Restorative	In-network out-of-pocket maximum is $3,000, out-of-network maximum is $2,000. Total out-of-pocket costs will not exceed $3,000 combined for in- and out-of-network services.
Tier 3	$50 per person, but not more than $150 total; waived for Preventive Care and Orthodontic Service	**IN-NETWORK** 100% - Preventive Care 70% - Basic Restorative 50% - Major Restorative	**OUT-OF-NETWORK** 90% - Preventive & Diagnostic Care 50% - Basic Restorative 40% - Major Restorative	In-network out-of-pocket maximum is $3,000, out-of-network maximum is $2,000. Total out-of-pocket costs will not exceed $3,000 combined for in- and out-of-network services.
Tier 4*	$50 per person per calendar year, but not more than $100 total; waived for Preventative Care and Orthodontic Services	**IN-NETWORK** 100% - Preventive Care 80% - Basic Restorative 65% - Major Restorative 50% - Periodontics and Prosthodontics	**OUT-OF-NETWORK** 90% - Preventive & Diagnostic Care 70% - Basic Restorative 55% - Major Restorative 40% - Periodontics and Prosthodontics	In-network out-of-pocket maximum is $3,000, out-of-network maximum is $2,000. Total out-of-pocket costs will not exceed $3,000 combined for in- and out-of-network services.

** Tier 4 applies to SEHBP DEP Plus only.*

Filing Deadline – Proof of Loss

Aetna or Horizon 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, 2024, you would have until April 30, 2026 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.

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; and
- Charge for each service.

Predetermination of Benefits/ Pretreatment Estimates

Predetermination of benefits (Aetna terminology) or a pretreatment estimate (Horizon terminology) are voluntary processes that allow you to know what services are covered and the estimated payment based on the information provided 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 a predetermination of benefits or pretreatment estimate.

This feature of the SEHBP Retiree DEPs ensures that both you and the dentist will know in advance what part of the dentist's charges the plan will pay. If possible, treatment should be completed within 90 days of receiving the approved predetermination of benefits or pretreatment estimate.

The predetermination of benefits/pretreatment estimate provision of the SEHBP Retiree DEPs is important, because under the alternative procedures provision (see the "Alternative Procedures" section), Aetna and Horizon have 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/Pretreatment Estimates Work — Your dentist submits a treatment plan and Aetna or Horizon determines the amount the SEHBP Retiree DEPs will pay and informs you and the dentist of its payment decision. You and your dentist should discuss the payment before the work is started .

Predetermination of benefits and pretreatment estimates will help you avoid surprises . Most dentists are familiar with these procedures; if not, they should call Aetna at 1-877-STATENJ (1-877-782-8365) or Horizon at 1-833-597-SHBP (1-833-597-7427). If your dentist submits a treatment plan for a predetermination of benefits or pretreatment estimate and then alters the course of treatment, Aetna or Horizon will adjust their payments accordingly. If the dentist makes a major change in the treatment plan, they 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 so long as the result 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.

SEHBP DEP/DEP PLUS SERVICES ELIGIBLE FOR REIMBURSEMENT

See the Glossary for a definition of terms.

- Oral evaluations covered at 80, 90, or 100 percent in-network, or at 70, 80, or 90 percent out-of-network depending on your benefit tier (limited to twice in a calendar year). Emergency or limited oral evaluations are covered, limited to one evaluation per patient, per year. Periodontal maintenance evaluations are included as oral evaluations.
- 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 in a 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 the removal of plaque, calculus, and stains from tooth structures (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.
- 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).

- Periodontics procedures (reimbursement for periodontal surgical procedures, usually provided for a specific quadrant, is limited to one surgical-type procedure, per quadrant every 36 months). Reimbursement for periodontal scaling and root planing procedures per specific quadrant is limited to one procedure in a 12-month interval.
- Periodontal surgical procedures, usually provided for specific quadrants, are subject to a reduced reimbursement when the number of diseased teeth in a quadrant are less than four. Additional reduction in benefits may apply, when multiple types of procedures are provided in the same quadrant, at the same appointment.
- 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.
- Routine extractions of teeth.
- Endodontic services, such as pulpotomy and root canal therapy.
- Space maintainers (other than for orthodontic treatment).
- Oral surgical procedures considered dental in nature — such as, but not limited to: surgical extractions, treatment of fractures, removal of lesions of the mouth, and alveolectomy.
- Apicoectomy.
- General anesthesia (including conscious sedation coverage) when medically necessary and in connection with covered oral and periodontal surgical procedures.
- Dental Implants.

ORTHODONTIC SERVICES ELIGIBLE FOR REIMBURSEMENT (DEP PLUS ONLY)

Certain charges for orthodontic procedures are eligible if:

- The orthodontic treatment is for a child covered under the SEHBP DEP Plus 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 the teeth (malposition) or abnormal bite (malocclusion);
- The service or supply is part of a treatment plan submitted by the dentist and approved by Aetna or Horizon 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 SEHBP DEP Plus" section.

SEHBP DEP/DEP PLUS SERVICES NOT ELIGIBLE FOR REIMBURSEMENT

- Orthodontic Services (DEP only)
- Gold restorations other than crowns, inlays, and onlays.
- Any service or item not reasonably necessary for the dental care of the patient.
- Protective devices such as athletic mouth guards.
- Plaque control.
- Myofunctional therapy.
- A charge in connection with appliances, restorations, or procedures needed to alter vertical dimensions or restore occlusion, or for the purpose of splinting or correcting attrition, abrasion, or erosion.
- Crowns, inlays, or onlays if used in splinting procedures during periodontal treatment.
- Charges for sterilization or asepsis.
- 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 not reasonably necessary 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 plan; except that a procedure will not have been considered to have started with an oral prophylaxis or a diagnostic procedure.
- Any service or supply which is furnished or made available to a patient or financed by federal, State, or local government, including Medicare or a like plan, Workers' Compensation law or a similar law, any automobile no-fault law, or any other plan or law under which the patient is or could be covered, whether or not the patient makes any claim or receives compensation under it.
- Any charge incurred after the patient is no longer covered, except in the case of an extension of coverage (see the "Extension of Coverage Provisions" section).
- Any charge for a service that is more than the reasonable and customary allowance (see the "Reasonable and Customary Allowance" section).
- Any charge for a service rendered by a member of the patient's immediate family (including you, your spouse/partner, your child, brother, sister, or parent of you or your spouse/partner).
- Any service or supply other than those specifically covered under this program.
- Services and supplies provided in connection with treatment or care that is not covered under the plan.

ORTHODONIC CHARGES NOT ELIGIBLE UNDER THE SEHBP DEP PLUS

- 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.
- 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 the 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.

If dissatisfied with a final health plan decision on a dental appeal, only the member or the member's legal representative (this does not include the provider of service) may appeal, in writing, to the State Health Benefits Commission. If the member is deceased or incapacitated, the individual legally entrusted with their affairs may act on the member's behalf. Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to the following address:

Appeals Coordinator
State Health Benefits Commission
P.O. Box 299
Trenton, NJ 08625-0299

Notification of all Commission decisions will be made in writing to the member. If the Commission approves the member's appeal, the decision is binding upon the dental plan. 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 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 (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify, or reject. If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, 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. You will be responsible for any court filing fees or related costs that may be necessary during the appeal's process. If you require an attorney or expert dental testimony, you will be responsible for any fees or costs incurred.

HIPAA PRIVACY

The Retiree Dental Plans make every effort to safeguard the dental information of their members and complies with the privacy provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA requires health plans to maintain the privacy of any personal information relating to its members' physical or mental health. See Appendix III (on page 27) for the SHBP/SEHBP's Notice of Privacy Practices.

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, or birth certificates, or tax returns are required. 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.

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 t he 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

NOTICE OF PRIVACY PRACTICES TO ENROLLEES

State Health Benefits Program
School Employees' Health Benefits Program

This Notice describes how medical 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 on our website at: ***www.nj.gov/treasury/pensions*** 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 treatment records, or any other information created by others. 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: Members have 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: Members have 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, members 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.

APPENDIX IV

PARTICIPATING RETIREE DENTAL PLANS

Plan Name	Web Addresses and Membership Services Phone Number
Aetna DMO	***www.aetna.com/statenj*** 1-877-STATENJ (1-877-782-8365)
Aetna Dental Expense Plan/ Dental Expense Plan Plus (PPO Administered by Aetna)	***www.aetna.com/statenj*** 1-877-STATENJ (1-877-782-8365)
Horizon Dental Expense Plan/ Dental Expense Plan Plus (PPO Administered by Horizon)	***www.horizonblue.com/shbp*** 1-833-597-SHBP (1-833-597-7427)

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 below.

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:

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

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

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.