



# Yale University - Group No. 4630

Dental Plan For  
Faculty, Post-Doctoral Associates  
& Fellows And Managers & Professional  
Staff

*Advancing Solutions For  
Great Oral Health*

January 1, 2016

# ADA American Dental Association® Dental Claim Form

## HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

- Statement of Actual Services       Request for Predetermination/Preauthorization  
 EPSDT / Title XIX

2. Predetermination/Preauthorization Number

## POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

## INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)

14. Gender

- M  F

15. Policyholder/Subscriber ID (SSN or ID#)

## OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental?  Medical?  (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in # 4 (Last, First, Middle Initial, Suffix)

16. Plan/Group Number

17. Employer Name

6. Date of Birth (MM/DD/CCYY)

7. Gender

- M  F

8. Policyholder/Subscriber ID (SSN or ID#)

## PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above

- Self  Spouse  Dependent Child  Other

19. Reserved For Future Use

9. Plan/Group Number

10. Patient's Relationship to Person named in #5

- Self  Spouse  Dependent  Other

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)

22. Gender

- M  F

23. Patient ID/Account # (Assigned by Dentist)

## RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier  (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) A \_\_\_\_\_ C \_\_\_\_\_  
 (Primary diagnosis in "A") B \_\_\_\_\_ D \_\_\_\_\_

31a. Other Fee(s)

32. Total Fee

35. Remarks

## AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X \_\_\_\_\_  
 Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X \_\_\_\_\_  
 Subscriber Signature Date

## ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment  (e.g. 11=office; 22=O/P Hospital)  
 (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N)

40. Is Treatment for Orthodontics?  
 No (Skip 41-42)  Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment

43. Replacement of Prosthesis  
 No  Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from

- Occupational illness/injury  Auto accident  Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

## BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

## TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X \_\_\_\_\_  
 Signed (Treating Dentist) Date

54. NPI

55. License Number

56. Address, City, State, Zip Code

56a. Provider Specialty Code

49. NPI

50. License Number

51. SSN or TIN

52. Phone Number

52a. Additional Provider ID

57. Phone Number

58. Additional Provider ID

# ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

## GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.
- B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.
- C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- D. All dates must include the four-digit year.
- E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

## COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

## DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

## PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

- 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "[www.cms.gov/PhysicianFeeSched/Downloads/Website\\_POS\\_database.pdf](http://www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf)"

## PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
<b>Dentist</b> A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
<b>General Practice</b>	1223G0001X
<b>Dental Specialty</b> (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "[www.wpc-edi.com/codes/taxonomy](http://www.wpc-edi.com/codes/taxonomy)"

# Delta Dental Offers Enhanced Explanation of Benefits Statements

Delta Dental's **Explanation of Benefits** statement is presented in a readable, user-friendly format. Developed in consultation with dentists and members, the form is formatted for ease of reading.

## What Delta Dental's Explanation of Benefits Statement Offers

- CONTACT INFORMATION**, including a special Customer Service toll-free phone number.
- A PAYMENT SUMMARY BOX**, providing at a glance details about charges, payments, deductibles, patient obligations, and Dentist Amount Non Billable (which shows the amount the patient is not billed for).
- PATIENT INFORMATION**, including patient's name, relationship to subscriber, benefit period, group ID and name, and plan type.
- CLAIM NUMBER** includes 15 digits.

continued on other side



1



Delta Dental of New Jersey, Inc.  
P.O. Box 222  
Parsippany, NJ 07054

Claim Inquiries: 800-452-9310 Visit us on the Internet: www.deltadentalnj.com

### Explanation of Benefits – Dentist Copy

\*See Reverse side if this is not your patient.

#### PAYMENT SUMMARY

<b>Total Approved Charges</b>	\$000.00
<b>Delta Dental's Total Payment</b>	\$000.00
<b>Your Other Insurance Paid</b>	\$000.00
<b>Applied to Deductible</b>	\$000.00
<b>Dentist Amount Non Billable</b>	\$000.00
<b>Patient Out of Pocket Payment Obligation</b>	\$000.00

**DO NOT SEND PAYMENT TO DELTA DENTAL**

2

JOHN SMITH DMD  
1234 ANY STREET  
SAMPLETOWN, NJ 00000-0000

3

**MEMBER:** ROBERT JONES  
**PATIENT:** ROBERT JONES  
**RELATIONSHIP:** SUBSCRIBER  
**GROUP ID:** 0000-0000  
**GROUP NAME:** ABC CORPORATION  
**PLAN TYPE:** PREMIER

**CLAIM NUMBER:** 0000000000000000  
**DATE OF ISSUE:** 00/00/00  
**CHECK NUMBER:** 0000000000  
**DENTIST ID NUMBER:** 12345NJ  
**DENTIST NAME:** DR. JOHN SMITH  
**PAR STATUS:** PREMIER  
**BENEFIT PERIOD:** 00/00/0000 – 00/00/0000

4

5

6

Annual **PLAN MAXIMUM:** \$0000.00 Individual **Used to Date:** \$000.00

7

TOOTH NO. OR LETTER	SURFACE	DATE OF SERVICE	SUBMITTED PROCEDURE NO.*	PAID PROCEDURE NO.*	SUBMITTED AMOUNT	APPROVED AMOUNT	AMT USED FOR BENEFIT CALC	DED	% COPAY	DELTA DENTAL PAYMENT	PROCESSING POLICIES
XX	XXXXX	00/00/0000	2391	2140	\$000.00	\$000.00	\$000.00	\$00.00	000	\$000.00	000, 000, 000

**\*PROCEDURE NO. / DESCRIPTION**

2391 Resin based composite – one surface, posterior  
2140 Amalgam – one surface, posterior

**NOTICES**

Payment was mailed to the subscriber.

PLEASE SEE REVERSE SIDE OF THIS FORM FOR INFORMATION RELATED TO OUR NOTICE OF PRIVACY PRACTICES, DEFINITIONS, AND OTHER IMPORTANT INFORMATION.

## IMPORTANT NOTICE TO CLAIMANTS

### 1. Informal Review (Optional to Member)

The covered person (or authorized representative) and/or treating dentist may, within 60 days of the date of mailing of this EOB, request that we informally reconsider this claim decision by following the procedure described in No. 6 below; we will respond within 60 days and notify the member (or authorized representative) and treating dentist of our decision and the reason(s) therefor. If no request is submitted within 60 days, only a formal appeal may be filed. A request for informal review does not constitute an "appeal" for ERISA appeals purposes.

### 2. Formal Appeal

The covered person (or authorized representative) may, within 240 days of the date of mailing of this EOB, formally appeal this claim decision by following the procedure described in No. 6 below; we will issue our decision to the member (or authorized representative) within 30 days of our receipt of the appeal for ERISA claims and within 45 days of our receipt of the appeal for non-ERISA claims.

### 3. Right to Sue

A covered person must timely file a formal appeal (as described in No. 2 above) and receive our decision on the appeal as a precondition to commencing any legal proceeding challenging the claim determination.

### 4. Right to Receive Rules, Guidelines or Detailed Explanations

If the front side of this form indicates that a rule or guideline was relied on, you have a right to receive it free of charge. If the front side indicates that payment was not made for services because they were experimental or not medically necessary, you have a right to receive an explanation of the basis for that decision. To receive either, send your written request to Delta Dental, Attn: Correspondence Department, P.O. Box 222, Parsippany, NJ 07054.

### 5. Dentist Request to Speak with a Dental Consultant

A "dental decision" is a decision which is based upon a dental diagnosis or dental judgment. If the front side of this form reports a denial, reduction or failure to provide payment, in whole or in part, for a service based upon a "dental decision" AND (a) you are a New Jersey licensed dentist AND (b) you disagree with such determination, then you have the right to speak with a dentist at Delta Dental concerning the dental basis for the dental decision. As a precondition, you must submit a written and signed explanation of the basis for your disagreement within the time period for challenging the claim determination to Delta Dental, Attn: Adverse Determination Review, P.O. Box 617, Parsippany, NJ 07054. We urge you to include any documentation you want us to consider.

### 6. Procedure for Requesting Informal Reviews and Formal Appeals

Submit the following information and documentation:

- (a) Dentist name, office name, address and license number
- (b) Member name, Member ID number (which in many cases is the primary subscriber's social security number)
- (c) Patient name and date of birth
- (d) Claim number
- (e) Whether this is for an informal review or a formal appeal

- (f) Description of the reasons why Delta Dental should change its initial decision on the claim and the specific decision which you request
- (g) Any supplemental information or diagnostic materials relevant to the claim in question
- (h) In lieu of (a), (b), (c) and (d), attach a copy of the claim and the claim determination you are appealing

A form is available for you to use at [http://www.deltadentalnj.com/HIPAA/law\\_compliance.shtml](http://www.deltadentalnj.com/HIPAA/law_compliance.shtml).

You must sign your request; if you are authorized to act for the covered person, you must state that. You may include information and/or documentation pertinent to the claim even if you had not previously submitted it to us. Informal review requests must be addressed to Delta Dental, Attn: Informal Review Department, P.O. Box 601, Parsippany, NJ 07054. Formal appeals must be addressed to Delta Dental, Attn: Formal Appeals Department, P.O. Box 601, Parsippany, NJ 07054.

### 7. Potential Voluntary Alternative Dispute Options

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency. Those persons covered under a self-funded program may also have a voluntary appeals program available to them; check with your Human Resources Department or Summary Plan Description (SPD) if applicable.

### 8. Notice of Privacy Practices

You may access Delta Dental's Notice of Privacy Practices on our website at [www.deltadentalnj.com](http://www.deltadentalnj.com). You may also obtain a hard copy of this notice by contacting our compliance administrator at (866) 861-4716.

### 9. Coordination of Benefits

If you are covered by more than one health benefit plan, you should file all your claims with each plan and provide each plan with information regarding the other plans under which you are covered.

You should always submit your claim first to your primary carrier and, after receiving their determination, submit your claim to your secondary or tertiary carriers (if applicable).

### 10. Terminology and Definitions

**Approved Amount:** The total amount which the dentist is permitted to collect as payment in full for the specified service. It includes the dental benefit plan's payment as well as the patient's deductible and/or copay.

**Amount Used for Benefit Calculation:** The fee amount that the dental benefit plan provides for use in calculating the dental benefit plan payment for the specified service. The dental benefit plan payment may be less than this fee amount due to patient deductible, copay, plan limitations or exclusions.

11. Any procedures which are disallowed resulting in no Delta Dental payment or patient liability are in accordance with the group contract and dentist participation agreement.

12. Payment for all services is determined in accordance with the terms of the group's dental plan and/or with the terms of Delta Dental's dentist participation agreements.

*If you have received this in error, please sign to confirm that you have not retained a copy of this document or any of the patient information. Please return this document to Delta Dental, Attn: Correspondence Department, P.O. Box 222, Parsippany, NJ 07054. Signature: \_\_\_\_\_*

- 5. DENTIST INFORMATION**, including the Delta Dental program in which he or she participates for that claim.
- 6. MAXIMUM INFORMATION** includes all maximums applicable to the plan the patient is covered under instead of showing plan maximum only.
- 7. DETAILED EXPLANATIONS AND DESCRIPTIONS OF INFORMATION IN THE COLUMNS**, including descriptions of each procedure number and explanations, if appropriate, of processing policies (up to 3 per line item allowed). Also features separate '**Submitted Procedure No.**' and '**Paid Procedure No.**' to better illustrate when an alternative benefit has been applied.

For questions about specific claims, contact the number for Claims Inquiries on your Explanation of Benefits statement, or e-mail Customer Service at [service@deltadentalnj.com](mailto:service@deltadentalnj.com).



## Description of Covered Services

### **Faculty, Post Doctoral Associates and Fellows, Managerial, Professional Employees**

	<b>Plan Pays:</b>
Calendar Year Maximum (per person)	\$2,500.00
Calendar Year Deductible	
Individual	\$50.00
Family	\$100.00

#### **Preventive & Diagnostic Services (No Deductible)** 100%

- Exams, Cleanings, (each twice per calendar year per person, ages 14 and older are considered adults)
- X-rays-full mouth series or panoramic (either one, once in three years)
- X-rays-bitewing (maximum of four films per calendar year)
- X-rays-single films (multiple x-rays on the same date of service will not exceed the benefit of a full-mouth series)
- Fluoride Treatment (two per calendar year, for eligible children to age 19, combinations with cleanings are applied to time limits for both)
- Space Maintainers (twice per space per lifetime, for children under age 19)
- Consultations are counted as exams for purposes of frequency limitations.
- Sealants (1<sup>st</sup> and 2nd permanent, decay-free molars, once per tooth in any 36 consecutive months, for children to age 14)

#### **Basic Services (After Deductible)** 80%

- Fillings - composite and amalgam. Payment is allowed for one restoration per tooth surface in 365 days.
- Extractions, Oral Surgery (impacted wisdom teeth claims should first go to medical carrier)
- Endodontics (root canals on permanent teeth and root surgery each once per 24 months)
- Periodontics, Periodontal Surgery – Pre-treatment estimate is strongly recommended
- Repair & relining of dentures (repair of existing prosthetic appliances once per 36 months)
- Emergency Care (necessary palliative treatment for minor dental pain)

#### **Prosthodontics & Crowns (After Deductible)** 50%

- Crowns and crown-related procedures (post and core, core buildup, etc., once every five years, permanent teeth only, for ages 12 and older).
- Bridgework (once every five years, for ages 16 and older) (bridges with four or more missing teeth in that arch may be given an alternate benefit of a partial denture)
- Full & Partial Dentures (either one, once every five years, partial dentures for ages 16 and older) (fixed bridges and removable partial dentures are not benefits in the same arch; benefits will be provided for the removable partial denture only)
- Inlays (inlays are only payable when done in conjunction with an onlay; by themselves they are given the alternate benefit of an amalgam filling)
- Crown Lengthening
- Implants
- General anesthesia (when medically necessary)
- Occlusal Adjustments

Benefits are payable based on date of treatment completion for all non-orthodontic procedures.

**Orthodontia (Employee & Dependents)**

50%

Orthodontic treatment is a benefit limited to once in a lifetime.

- Maximum per individual \$2,000.00

Under all programs, non-participating dentists may balance bill above the maximum allowable charge.

**Orthodontic Payment Schedule**

Payment for comprehensive orthodontics will be processed in two (2) equal payments (subject to continuation of treatment and/or eligibility for orthodontic benefits at the time services are rendered).

The first payment will be made upon insertion of appliances. The second and final payment will be made upon the completion of the first twelve (12) months of treatment if member is eligible and enrolled at that time. These payments will represent Delta Dental's full liability.

When the appliances are inserted prior to the effective date of eligibility, orthodontic benefits will be *pro-rated*.

***Eligibility Requirements***

You are eligible for dental coverage if you satisfy one of the following requirements:

- You are a faculty member, post-doctoral associate or fellow with an appointment of at least 50% time
- You are a managerial & professional employee scheduled to work at least 20 hours per week

Visiting faculty are **not** eligible for dental coverage.

The following dependents are considered "eligible dependents" in accordance with Section 152 of the Internal Revenue Code.

- Your legal spouse, civil union partner or domestic partner on file prior to April 1, 2006
- Unmarried dependent children until the end of the month in which they reach age 26
- Disabled dependent children, regardless of age

## **Civil Union Partners**

Please view the Civil Union & Same Sex Spouse Marriage policy, revised 01/2009 online at

[www.yale.edu/benefits](http://www.yale.edu/benefits)

### ***When does coverage begin?***

Coverage for a faculty member, post-doctoral associate or fellow, managerial or professional staff begins on the 1<sup>st</sup> day of the month following the employee's date of hire or on the 1<sup>st</sup> day of the month if the staff employee's date of hire is the 1<sup>st</sup> of the month.

### ***When does coverage terminate?***

Coverage for employees and their eligible dependents shall cease upon the earliest of:

- End of the calendar month in which employee termination occurs
- End of the calendar month in which the death of employee occurs
- End of the calendar month in which the termination of group contract occurs

Coverage for a dependent spouse shall terminate at the end of the calendar month in which the divorce from the covered employee occurs unless otherwise stated by divorce decree.

Coverage for a dependent child shall terminate upon the end of the calendar month of attaining the limiting contract age (see eligibility section).

For coordination of benefits, Yale uses the birthday rule to establish which coverage is primary.

### **Exclusions and Limitations: Services Not Covered by This Dental Plan**

- To be eligible for coverage, a service must be required for the prevention, diagnosis, or treatment of a dental disease, injury, or condition. Services not dentally necessary are not covered benefits. Your dental plan is designed to assist you in maintaining dental health. The fact that a procedure is prescribed by your dentist does not make it dentally necessary or eligible under this program. We can request proof (such as x-rays, pathology reports, or study models) to determine whether services are necessary. Failure to provide this proof may cause adjustment or denial of any procedure performed.
- Services for injuries or conditions which are compensable under Workers Compensation Employers Liability Laws; services provided to the eligible patient by any Federal or State Government Agency or provided without cost to the eligible patient by any municipality, county, or other political subdivision.
- Services with respect to congenital or developmental malformations (including TMJ and replacing congenitally missing teeth), cosmetic surgery, and dentistry for purely cosmetic reasons (e.g., bleaching, veneers, or crowns to improve appearance).
- Services provided in order to replace tooth structure lost by wear, abrasion, attrition, abfraction, or erosion; splint teeth; or treat or diagnose jaw joint and muscle problems (TMJ).
- Specialized or personalized services (e.g., overdentures and root canals associated with overdentures, gold foils) are excluded and a benefit will be allowed for a conventional procedure (benefiting a conventional denture towards the cost of an overdenture and the root canals associated with it. The patient is responsible for additional costs.)
- Prescribed drugs, analgesics (pain relievers), fluoride gel rinses, and preparations for home use.
- Orthodontic procedures to achieve minor tooth movement.
- Experimental procedures, materials, and techniques and procedures not meeting generally accepted standards of care.
- Educational services such as nutritional or tobacco counseling for the control and prevention of oral disease. Oral hygiene instruction or any equipment or supplies required.



- Services rendered by anyone who does not qualify as a fully licensed *dentist*, except those legally delivered services by licensed dental personnel under the direct supervision of a dentist.
- Charges for hospitalization including hospital visits or broken appointments, office visits, and house calls.
- Services performed prior to effective date or after termination of coverage. Benefits are payable based on date of completion of treatment.
- Services performed for diagnosis such as laboratory tests, caries tests, bacterial studies, diagnostic casts, or photographs.
- Temporary procedures and appliances, pulp caps, inhalation of nitrous oxide, analgesia, local anesthetic, and behavior management.
- Procedures or preparations, which are part of or included in the final restoration (bases, acid etch, or micro abrasion).
- Composite restorations on posterior teeth are given the alternate benefit of an amalgam filling.
- Periodontal charting, chemical irrigation, delivery of local chemotherapeutic substances, application of desensitizing medicine, synthetic bone grafts, and guided tissue regeneration.
- Post removal (not in conjunction with root canal therapy).
- Completion of claim forms, providing documentation, requests for pre-determination, and services submitted for payment more than twelve (12) months following completion.
- Separate fee for infection control and OSHA compliance.

This is a general description of your dental plan to be used as a convenient reference, and some exclusions and limitations may not be listed. All benefits are governed by your group contract.

### **About Delta Dental**

Delta Dental of New Jersey, Inc. covers more than one million people in commercial, school board, and government programs. It is our mission to promote oral health to the greatest number of people by providing accessible dental benefits programs of the highest quality, service, and value.

Since 1969, Delta Dental, a not-for-profit dental service corporation, has led the industry in offering innovative programs designed to control costs while ensuring quality of benefits.

Delta Dental is a member of the Delta Dental Plans Association, a national system of not-for-profit dental service corporations covering 28 million people across the country. The national Delta Dental system is the oldest and largest dental benefits system in the country.

### **Delta Dental PPO plus Premier**

Delta Dental offers two networks under this plan – Delta Dental Premier and Delta Dental PPO. You may use any dentist under this plan. You will maximize your benefits by using an in-network dentist.

Delta Premier is the larger of the two networks and has modest discounts. Delta Dental PPO is a smaller network, but fees are more deeply discounted.

When you use a Delta Dental PPO dentist, the fee for the covered service(s) will not exceed the Delta Dental PPO maximum allowable charge(s).

When you use a Delta Dental Premier dentist, the maximum fee for a covered service will not exceed the contracted Premier fee.

Claims for services provided by dentists who are neither Delta Dental Premier or Delta Dental PPO dentists are paid based on the lesser of the dentist's actual charge or Delta Dental's maximum allowable charge.

## How to Use Your Program

Before visiting the *dentist*, check to see whether your *dentist* participates with Delta Dental in your program (e.g., *Delta Dental PPO plus Premier*).

At the time of your first appointment, tell your *dentist* that you are covered under this Delta Dental program. Give him or her your group's name and group number, as well as your Member's ID number. Your dependents, if covered, also must give your ID number.

After your *dentist* performs an examination, he or she may submit a *Pre-Treatment Estimate* of benefits to Delta Dental to determine how much of the charge will be your responsibility.

Before treatment is started, be sure you discuss with your *dentist* the total amount of his or her fee. Although *Pre-Treatment Estimates* are not required, Delta Dental strongly recommends you ask your *dentist* to submit a *Pre-Treatment Estimate* for treatment costing \$300 or more. This is especially important when using a *non-participating dentist* because the *Pre-Treatment Estimate* lets you know in advance how much of the costs are your responsibility. Please keep in mind that *Pre-Treatment Estimates* are only estimates and not a guarantee of payment.

## Locating a *Dentist*

Delta Dental offers two easy ways to locate a *participating dentist 24 hours a day, 7 days a week*. Subscribers can either:

- Call (800) DELTA-OK or 1-(800) 335-8265
- Search the Internet at [www.deltadentalnj.com](http://www.deltadentalnj.com)

By calling the toll-free number, you can obtain a customized list of *participating dentists* within the geographic area of your request. Delta Dental mails the list to your home.

By searching on the Internet, you can obtain a list of *participating dentists* in a specific town. The list can be downloaded immediately, and you can search for as many towns as needed.

Using either method, you can request a list of Delta Dental *participating dentists* within a designated area. You can specify listings of *general dentists* only or specialists only. *Participating dentist* information can be obtained for *dentists* nationwide.

## Why Select a *Participating Dentist*?

All Delta Dental *participating dentists* have agreed, in writing, to abide by our claims processing procedures. Through their commitment and support, we, in turn, can provide you with a program that's tailored to meet your dental health wants and needs.

- *Participating dentists* have agreed to accept the least of their actual charge, their prefiled fee, or Delta Dental's maximum allowable fee for the program as payment in full and to not charge patients for amounts in excess of those indicated in the "patient payment" portion of the *Explanation of Delta Dental Benefits*.
- *Participating dentists* will usually maintain a supply of *claim forms* (also referred to as Attending Dentist's Statements) in their office. You may be asked to complete a portion of the form when you visit.

- *Participating dentists* will complete the rest of the form, including a description of the services that were performed or will be performed in the case of a *Pre-Treatment Estimate*, and require that you sign the *claim form* in the appropriate place. For *dentists* who submit claims electronically to Delta Dental, you will need to authorize your *dentist* to maintain your signature on file.
- *Participating dentists* will mail, fax, or electronically submit the *claim form*, together with the appropriate diagnostic materials, directly to our offices for processing.
- *Participating dentists* agree to abide by Delta Dental processing policies. For example, *participating dentists* agree not to bill separate charges for infection control measures. *Non-participating dentists* are not bound by such policies.
- *Participating dentists* will, in the case of dental services which have been completed, receive payment directly from Delta Dental for that portion of the *treatment plan*, which is covered by your dental program. You will receive a *Notification of Delta Dental Benefits* with a detailed description of covered benefits and the amount of your obligation.
- If you visit a *non-participating dentist*, you will be responsible for payment. Delta Dental will reimburse you for the portion of your services covered by your program.

We advise that you check with your *dentist* to confirm whether he or she participates in the Delta Dental program under which you are covered. While a *dentist* may participate with Delta Dental, he or she may not participate in all of our programs.

#### Where Do I Call/E-mail?

<u>Question</u> Customer	<u>Phone Number</u>	<u>E-mail/Internet Address</u>
Service	(800) 494-4138	service@deltadentalnj.com
Obtain <i>claim forms</i>	(800) 494-4138	service@deltadentalnj.com
<i>Explanation of Delta Dental Benefits</i> statement	(800) 494-4138	service@deltadentalnj.com
Status of a claim	(800) 494-4138	service@deltadentalnj.com
Eligibility information	(800) 494-4138	service@deltadentalnj.com
Benefits information	(800) 494-4138	service@deltadentalnj.com
Completing the <i>claim form</i>	(800) 494-4138	service@deltadentalnj.com
<i>Participating dentist</i> list	(800) DELTA-OK (800) 335-8265	www.deltadentalnj.com

Please note that all calls to our toll-free number first go through our *Interactive Voice Response (IVR)* system. Information available on the *IVR* includes eligibility, benefits, remaining maximum, *deductible*, claim payments, and ordering *claim forms*. Your question may be answered quicker by the *IVR*, where there is never a wait. You can also use this system to speak with a Customer Service representative. Note: A touch-tone phone is required.

We offer the following services for our non-English speaking and hearing-impaired subscribers: Language

Line Helper - a non-English speaking subscriber can also use our toll-free number.

When the call is received, a translator will be obtained for the language the caller is fluent in and a three-way conversation will be held among the caller, translator, and a Delta Dental customer service representative.

TDD Line - a hearing-impaired subscriber can call (800) 246-1020 Monday through Thursday, 8:00 a.m. – 6:30 p.m. EST and 8:00 a.m.-5:00 p.m. EST Friday and be connected with a TDD machine to also access our Customer Service representatives.

## Frequently Asked Questions

- Do I need to have an assigned *dentist*?

No, this plan allows you to be treated by any licensed *dentist* of your choice. Generally, the least out-of-pocket expense can be achieved by using a network dentist (*Delta Dental PPO plus Premier*).

- Do I need a referral to a specialist?

You are not required to have a referral to a specialist if you or your dependents require specialized care. Generally, you will maximize your benefits by utilizing the services of a specialist who participates with Delta Dental.

- Is it required to have a *Pre-Treatment Estimate* (pre-determination of benefits)?

No, it is not required by Delta Dental that you obtain a *Pre-Treatment Estimate* of benefits prior to treatment. If your *dentist* indicates the need for treatment with dental charges in excess of \$300, it is strongly recommended that you request an estimate of dental benefits before receiving the treatment. Both you and your *dentist* will receive a voucher from Delta Dental showing the estimated payable benefit. It will also indicate your estimated patient responsibility including *deductible* if applicable. Your *dentist* needs to complete this voucher and submit it for payment when work has been completed. *Pre-Treatment Estimates* are only estimates and not a guarantee of payment. Payments of the approved services are subject to eligibility and to contract limitations (e.g., annual maximums) at the time services are rendered.

- Do I need an ID card as proof of coverage when I visit a *dentist*?

Although not required, you should show it to your *dentist*. An ID card does not verify active coverage. You or your *dentist* may obtain your group number, current eligibility and benefit information by contacting Delta Dental at (800) 494-4138, 24 hours a day, 7 days a week or by accessing Delta Dental's on-line Benefits Connection tool at [www.deltadentalnj.com](http://www.deltadentalnj.com).

- What if I have questions about my benefits?

You can call our Customer Service Department at (800) 494-4138 and speak to a representative Monday through Thursday, 8:00 a.m. – 6:30 p.m. EST and 8:00 a.m.-5:00 p.m. EST Friday. Also, our *interactive voice response* system can provide benefit, eligibility, remaining maximum and *deductible* information, and history of your recent claims 24 hours a day, 7 days a week along with Delta Dental's on-line Benefits Connection tool.

- How do I file a claim for dental charges?

There are several easy ways to submit a claim. Your *dentist* can complete a Delta Dental *claim form* or an ADA (American Dental Association) approved form and mail it to: Delta Dental of New Jersey, P.O. Box 222, Parsippany, NJ 07054-0222. The *claim form* may also be faxed to (800) 324-7939. If your *dentist* files claims electronically through his or her computer, no *claim form* is required. This method also speeds processing time.

Also, you may download a claim form from our web site and submit the claim as well.

- Is there a time limit for submitting dental claims?

Yes, you have one full year from the date of service to submit your dental claims. If there is coordination of benefits involved and Delta Dental is not the primary carrier, you have one year from the date on which the primary carrier(s) issues a statement of benefits. If the claim is submitted after these timeframes, then the services are not covered.

- How do eligible children attending college away from home find a *participating dentist*?

A customized list of *participating dentists* for a specific geographic location can be obtained by calling (800) DELTA-OK or (800) 335-8265. This list will be mailed or can be faxed in case of an emergency situation. Also, listings of *participating dentists* throughout the country are available on our web site at [www.deltadentalnj.com](http://www.deltadentalnj.com).

- If I am not located in the same state as my employer's headquarters, where do I call?

No matter where you are located in the country, you can still call the same toll-free number (800) 494-4138 to reach our Customer Service Department, Monday through Thursday, 8:00 a.m. – 6:30 p.m. EST and 8:00 a.m.-5:00 p.m. EST Friday. Our *Interactive Voice Response* system is available 24 hours a day, 7 days a week.

- What if more than one visit is necessary to complete treatment?

Benefits are payable based on date of completion of treatment.

- What is an *alternative benefit* and how does it work?

The *alternative benefit* provision of your group contract is applied when there are two dentally acceptable ways to treat a dental condition and both procedures are covered. In such cases your benefit is based on the treatment that cost less. This does not mean that your *dentist* made a poor recommendation. In fact, you may use Delta Dental's payment towards the treatment your choose. Since Delta Dental's payment is the same no matter which treatment your choose, you may have higher out-of-pocket expense if you choose the treatment that cost more.

- For more Frequently Asked Questions, please visit Delta Dental's web site at [www.deltadentalnj.com](http://www.deltadentalnj.com).



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