Everything you need to know about your dental plan
AmeriHealth Insurance Company of New Jersey

Whose main office address is
259 Prospect Plains Road
Cranbury, NJ 08512

This Certificate of Insurance provides information about Your dental coverage. Read it carefully and keep it in a safe place with Your other valuable documents. Review it to become familiar with Your benefits and when You have a specific question regarding Your coverage.

To offer these benefits, Your Group has entered into a Group Policy of insurance with AmeriHealth New Jersey. The benefits are available to You as long as the Premium is paid and obligations under the Group Policy are satisfied. In the event of conflict between this Certificate and the Group Policy, the Group Policy will rule. This Certificate is not a summary plan description under the Employee Retirement Income Security Act (ERISA).

If You have any questions about Your coverage or benefits, please call our Customer Service Department toll-free at:

1-866-568-5994 (TTY: 711)

For general information, Network Dentist or benefit information, You may also log on to:

www.amerihealthnj.com/provider_finder

Claim forms should be sent to our Dental Claims Administrator, United Concordia:

United Concordia Companies, Inc.
Dental Claims Administrator
PO Box 69444
Harrisburg, PA 17106-9444

This booklet/certificate is subject to the laws of the State of New Jersey
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Attached:

- Appeal Procedure Addendum
- Schedule of Benefits
- Schedule of Exclusions and Limitations
DEFINITIONS

Certain terms used throughout this Certificate begin with capital letters. When these terms are capitalized, use the following definitions to understand their meanings as they pertain to Your benefits and the way the dental Plan works.

**Annual Maximum(s)** - The greatest amount the Company is obligated to pay for all Covered Services rendered during a calendar year or Contract Year as shown on the Schedule of Benefits. Annual maximum(s) do not apply to individuals covered by pediatric essential health dental benefits.

**Certificate Holder(s)** - An individual who, because of his/her status with the Policyholder, has enrolled him/herself and/or his/her eligible Covered Dependents if applicable for dental coverage and for whom Premiums are paid.

**Certificate of Insurance (“Certificate”)** - This document, including schedules, addenda and/or endorsements, if any, which describes the coverage purchased from the Company by the Policyholder.

**Civil Union** - Includes parties to a civil union and civil union couples in any definition or use of the terms "marriage," "spouse," "family," “immediate family,” “dependent,” “next of kin,” and any other terms that denote marital or spousal relationship, as those terms are used throughout this Certificate. Company provides coverage to parties to a civil union and their dependents that is equivalent to coverage provided to married persons and their dependents under this Certificate.

**Coinsurance** - Those remaining percentages or dollar amounts of the Maximum Allowable Charge for a Covered Service that are the responsibility of either the Certificate Holder or his/her enrolled Dependents after the Company pays the percentages or dollar amounts shown on the Schedule of Benefits for a Covered Service.

**Company** – AmeriHealth Insurance Company of New Jersey, the insurer.

**Contract Year** - The period of twelve (12) months beginning on the Group Policy’s Effective Date or the anniversary of the Group Policy’s Effective Date and ending on the day before the Renewal Date.

**Coordination of Benefits (“COB”)** - A method of determining benefits for Covered Services when the Member is covered under more than one plan. This method prevents duplication of payment so that no more than the incurred expense is paid.

**Cosmetic** - Services or procedures that are not Dentally Necessary and are primarily intended to improve or otherwise modify the Member's appearance.

**Covered Service(s)** - Services or procedures shown on the Schedule of Benefits for which benefits will be covered subject to the Schedule of Exclusions and Limitations, when rendered by a Dentist.

**Deductible(s)** - A specified amount of expenses set forth in the Schedule of Benefits for Covered Services that must be paid by the Member before the Company will pay any benefit.

**Dental Claims Administrator** – refers to United Concordia Companies Inc.
Dentally Necessary or Dental Necessity - A dental service or procedure is determined by a Dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the Dentist and the prevailing standards of care in the professional community. The initial determination will be made by the Dentist in accordance with guidelines established by the Company. When there is a conflict of opinion between the Dentist and the Company on whether or not a dental service or procedure is Dentally Necessary, the opinion of the Company will be final with respect to the initial claim determination and appeal decisions. Determinations made by the Company can be reversed by an internal utilization review organization, a court of law, arbitrator or administrative agency having jurisdiction.

Dentist(s) – A person licensed to practice dentistry in the state in which dental services are provided. Dentist will include any other duly licensed dental professional practicing under the scope of the individual’s license when state law requires independent reimbursement of such practitioners.

Dependent(s) – Those individuals eligible to enroll for coverage under the Group Policy because of their relationship to the Certificate Holder.

This Group Policy is a Family Policy. Dependents eligible for coverage in this Family Policy include:
1. The Certificate Holder’s Spouse or domestic partner as defined by any applicable state law;
2. Any unmarried natural child, stepchild, adopted child or child placed with the Certificate Holder or the Certificate Holder’s Spouse or domestic partner by order of a court or administrative agency:
   (a) until the end of the month that the individual reaches age 26; or
   (b) until the end of the month that the individual reaches age 26 if he/she is a full-time student at an accredited educational institution and is chiefly reliant upon the Certificate Holder for maintenance and support; or
   (c) to any age if the individual is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

Effective Date - The date on which the Group Policy begins or coverage of enrolled Members begins.

Exclusion(s) – Services, supplies or charges that are not covered under the Group Policy as stated in the Schedule of Exclusions and Limitations.

Experimental or Investigative - The use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Company, determines is not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which was not granted at the time the services were rendered. The Company will rely on the advice of the general dental community including, but not limited to dental consultants, dental journals and/or governmental regulations, to make this determination.

Family Policy – A Group Policy that covers the Policyholder’s Certificate Holders and may also cover eligible Dependents, as defined in this Certificate.

Grace Period - A period of no less than thirty-one (31) days after Premium payment is due under the Group Policy, in which the Policyholder may make such payment and during which the protection of the Group Policy continues, subject to payment of Premium by the end of the Grace Period.
Group Policy - The agreement between the Company and the Policyholder, under which the Certificate Holder is eligible to enroll him/herself and/or his/her Dependents.

Lifetime Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services for an adult rendered during the entire time the Member is enrolled under the Group Policy, as shown on the Schedule of Benefits. Life time maximum(s) do not apply to individuals covered by pediatric essential health dental benefits.

Limitation(s) - The maximum frequency or age limit applied to a Covered Service set forth in the Schedule of Exclusions and Limitations.

Maximum Allowable Charge - The maximum amount the Plan will allow for a specific Covered Service.

Member(s) – Enrolled Certificate Holder(s) and their enrolled Dependent(s). Also referred to as “You” or “Your” or “Yourself”.

Network Dentist – A Dentist who has executed a Network Dentist Agreement with Us, under which he/she agrees to accept the Company’s Maximum Allowable Charges as payment in full for Covered Services.

Non-Network Dentist – A Dentist who has not signed a contract with Us to accept the Company’s Maximum Allowable Charges as payment in full for Covered Services.

Out-of-Network Reimbursement Schedule Amounts – These amounts are determined as a percentile of Dentist charges for Covered Services by grouping the Dentist charges into different geographical areas. The Out-of-Network Reimbursement Schedule Amounts in the geographical area of the dental office are used to calculate the Company’s payment for Covered Services on Non-Network Dentist claims. The source of the Dentist charge data is select charge data acquired by the Company supplemented where necessary by internal claim data. Out-of-Network Reimbursement Schedule Amounts are updated periodically. There is no connection between these amounts and the Maximum Allowable Charges for Network Dentists.

Out-of-Pocket Expense(s) – Costs not paid by Us, including but not limited to Coinsurance, Deductibles, amounts billed by Non-Network Dentists that are over the Maximum Allowable Charge for Network Dentists, or over the Out-of-Network Schedule Amounts for Non-Network Dentists, costs of services that exceed the Policy’s Limitations or Maximums, or for services that are Exclusions. The Certificate Holder is responsible to pay for Out-of-Pocket Expenses.

Out-of-Pocket Maximum – The limit on the Deductibles and Coinsurance for Covered Services provided by Network Dentists that the Certificate Holder is required to pay in a calendar year or Contract Year, as shown on the Schedule of Benefits. This maximum will only apply to pediatric services only. After this limit is reached, Covered Services from Network Dentists are paid 100% by Us for the remainder of the calendar year or Contract Year unless subject to the Schedule of Exclusions and Limitations.

Plan - Dental benefits pursuant to this Certificate and attached Schedule of Exclusions and Limitations and Schedule of Benefits.

Policyholder – means the Employer who purchased the Policy.

Premium - Payment made by the Policyholder in exchange for coverage of the Policyholder’s Members under this Group Policy.
Renewal Date - The date on which the Group Policy renews. Also known as “Anniversary Date”.

Schedule of Benefits - Attached summary of Covered Services, Coinsurances, Deductibles, Waiting Periods and maximums applicable to benefits payable under the Plan.

Schedule of Exclusions and Limitations – Attached list of Exclusions and Limitations applicable to benefits, services, supplies or charges under the Plan.

Special Enrollment Period – The period of time outside Your Group’s open enrollment period during which eligible individuals who experience certain qualifying events may enroll as Certificate Holders or Dependents in this Group Policy.

Spouse – The Certificate Holder’s partner by marriage, Civil Union, domestic partnership, as defined by any applicable state law, or by any union between two adults that is recognized by law in the state where this Group Policy is issued.

State Law Provisions Addendum – Attached document, if any, containing state law requirements that modify, delete, and/or add provisions to the Certificate of Insurance.

Termination Date - The date on which the dental coverage ends for a Member or on which the Group Policy ends.

Waiting Period(s) - A period of time a Member must be enrolled under the Group Policy before benefits will be paid for certain Covered Services as shown on the attached Schedule of Benefits.

We, Our or Us - The Company, its affiliate or an organization with which it contracts for a provider network and/or to perform certain functions to administer this Policy.
ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment
In order to be a Member, You must meet the eligibility requirements of Your Group and this Group Policy. We must receive enrollment information for the Certificate Holder, enrolled Dependents, and Policyholder. Provided that We receive applicable Premium, coverage will begin on the date specified in the enrollment information We receive. Your Group will inform Certificate Holders of its eligibility requirements.

If You have already satisfied all eligibility requirements on the Group Policy Effective Date and Your enrollment information and applicable Premium are supplied to Us, Your coverage will begin on the Group Policy Effective Date.

If You are not eligible to be a Member on the Group Policy Effective Date, You must supply the required enrollment information on Yourself and any eligible Dependents, as specified in the Definitions section, within thirty-one (31) days of the date You meet all applicable eligibility requirements.

Coverage for Members enrolling after the Group Policy Effective Date will begin on the first day of the month following the date specified in the enrollment information supplied to Us provided Premium is paid.

The Company is not liable to pay benefits for any services started prior to a Member’s Effective Date of coverage. Multi-visit procedures are considered “started” when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. Procedures started prior to the Member’s Effective Date are the liability of the Member or a prior insurance carrier.

Special Enrollment Periods - Enrollment Changes

After Your Effective Date, You can change Your enrollment during Your Group’s open enrollment period. There are also Special Enrollment Periods when the Certificate Holder may add or remove Dependents. These Special Enrollment Period life change events include:

- birth of a child;
- adoption of a child;
- court order of placement or custody of an individual;
- change in student status for an individual;
- loss of other coverage;
- marriage, civil union or other lawful union between two adults;
- domestic partnership.
- marriage, civil union or other lawful union between two adults;
- domestic partnership.

If You enrolled through Your Group, to enroll a new Dependent as a result of one of these events, You must supply the required enrollment change information within the Special Enrollment Period that is thirty-one (31) days from the date of the life change event. The Dependent must meet the definition of Dependent applicable to this Group Policy.

There are additional life change events that may permit You to add or remove Dependents or change Plans. In addition to the life change events noted above, the additional Special Enrollment Period events include changes in:
• incarceration status;
• citizenship, status as a national or lawful presence;
• income

The Special Enrollment Period during which You must supply the required enrollment change information the Company is thirty (30) days from the date of the life change event. The Dependent must meet the definition of Dependent applicable to this Group Policy.

Except for newly born or adoptive children, coverage for the new Dependent will begin on the first day of the month following the date specified in the enrollment information provided to Us or on the date dictated by the Company, as long as the Premium is paid.

Newly born children of a Member will be considered enrolled from the moment of birth. Adoptive children will be considered enrolled from the date of adoption or placement, except for those adopted or placed within thirty-one (31) days of birth who will be considered enrolled Dependents from the moment of birth. In order for coverage of newly born or adoptive children to continue beyond the first thirty-one (31) day period, the child’s enrollment information must be provided to Us and the required Premium must be paid within the thirty-one (31) day period.

For an enrolled Dependent individual who is a full-time student, evidence of his/her student status and reliance on You for maintenance and support must be furnished to Us within ninety (90) days after the child attains the limiting age shown in the definition of Dependent. Such evidence will be requested annually thereafter until the Dependent reaches the limiting age for students and his/her coverage ends.

For an enrolled Dependent individual who is mentally or physically handicapped, evidence of his/her reliance on You for maintenance and support due to his/her condition must be supplied to Us within thirty-one (31) days after the individual attains the limiting age shown in the definition of Dependent. If the Dependent is a full-time student at an accredited educational institution, the evidence must be provided within thirty-one (31) days after the Dependent attains the limiting age for students. Such evidence will be requested thereafter based on information provided by the Member’s physician, but no more frequently than annually.

Dependent coverage may only be terminated when certain life change events occur including death, divorce from a Spouse or dissolution of the Civil Union, domestic partnership, or any other union defined in the Policy or recognized by any state’s law reaching the limiting age or during open enrollment periods [ or specified in any applicable Late Entrant Rider to the Certificate of Insurance

Late Enrollment

If You or Your Dependents are not enrolled within thirty-one (31) days of initial eligibility or during the Special Enrollment Period specified for a life change event, You or Your Dependents cannot enroll until the next Special Enrollment Period or open enrollment period conducted for Your Group unless otherwise permitted by applicable law or specified in any applicable Late Entrant Rider to the Certificate of Insurance. If You are required by court order to provide coverage for a Dependent individual, You will be permitted to enroll the Dependent individual without regard to enrollment season restrictions.

Voluntary Disenrollment

If You chose to drop Your coverage or Your Dependents’ coverage under the Plan at any time during the Contract Year other than at open enrollment or during open enrollment, You will not be permitted to enroll Yourself or Your Dependents at a later time unless you supply proof of loss of Form 16957
coverage under another dental plan. The loss of coverage must be due to a valid life change event such as death, divorce, dissolution of a Civil Union, domestic partnership, any other union defined in this Policy or recognized by the State of New Jersey or change in employment status of Spouse. If You supply such proof, You will be permitted to re-enroll at the next open enrollment period. You will be considered a new enrollee with respect to application of any Waiting Periods or benefit level changes shown on the Schedule of Benefits.

HOW THE DENTAL PLAN WORKS

Choice of Provider

You may choose any licensed Dentist for services. However, Your Out-of-Pocket Expenses will vary depending upon whether or not Your Dentist is in Our network. If You choose a Network Dentist, You may limit Your Out-of-Pocket Expense. Network Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services. Also, if agreed by the provider, Network Dentists limit their charges for all services delivered to Members. To find a Network Dentist, visit Our website at www.amerihealthnj.com/provider_finder or call Us at the toll-free number in the Introduction section of this Certificate or on Your ID card. Subject to Your discretion, New Jersey licensed Dentists are required to complete and send claims directly to Us for processing.

If You use a Non-Network Dentist, You may have to pay the Dentist at the time of service and wait for Us to reimburse You. You will be responsible for the Dentist’s full charge [which may exceed the Out of Network Reimbursement Schedule Amount and result in higher Out-of-Pocket Expenses. If You experience an emergent dental condition and require treatment, Your out-of-pocket costs will be the same regardless of whether the dentist providing the services is a Network Dentist or a Non-Network Dentist. Subject to Your discretion, New Jersey licensed Dentists are required to complete and send claims directly to Us for processing.

BENEFITS

Covered Services

Benefits and any applicable Coinsurance, Deductibles, Annual Maximums, Lifetime Maximums, Out-of-Pocket Maximums and Waiting Periods are shown on the attached Schedule of Benefits. Covered Services shown on the Schedule of Benefits must be Dentally Necessary to this Group Policy and are subject to frequency or age Limitations detailed on the attached Schedule of Exclusions and Limitations.

No benefits will be paid for services, supplies or charges detailed under the Exclusions on the Schedule of Exclusions and Limitations, and no benefits will be paid for services on the Schedule of Benefits with a Coinsurance of zero (0).

Benefits

Benefits for individual under age nineteen (19) meet the minimum essential benefit requirements for pediatric oral health. A summary of these benefits is below. Refer to the Schedule of Benefits and Schedule of Exclusions and Limitations for more details regarding individual dental benefits and applicable Deductibles and Coinsurance. Prior authorization is only required for medically necessary orthodontia; no other services require prior authorization.
Under age 19, coverage is provided for diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services as listed below.

- Dental services are available from birth. A dental visit is encouraged at age one (1).
- A second opinion is allowed.
- Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Your Dentist keeps records of Your diagnostic and preventive services. You may use any Dentist You choose. If You change Dentists, it is recommended that You ask the new Dentists to request copies of diagnostic radiographs if recently provided. If they are not available, radiographs needed to diagnose and treat will be allowed.
- As explained in the Appeal Addendum, denials of services to the Dentist shall include an explanation and identify the reviewer, including their contact information.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials, as needed by report.
- Services that are Experimental are not covered.
- This Group Contract will not cover any charges for broken appointments.

**Diagnostic Services**

* Indicates services that can be covered every three (3) months for individuals with special healthcare needs.

a) Clinical oral evaluations once every 6 months *
   - Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
   - Periodic oral evaluation – subsequent thorough evaluation of an established patient*
   - Oral evaluation for patient under age three (3) and counseling with primary caregiver*
   - Limited oral evaluations that are problem focused
   - Detailed oral evaluations that are problem focused

b) Diagnostic imaging with interpretation
   - A full mouth series can be provided every three (3) years. The number of films/views expected is based on age with the maximum being sixteen (16) intraoral films/views.
   - An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   - Additional films/views needed for diagnosing can be provided as needed.
   - Bitewings, periapicals, panoramic and cephalometric radiographic images
   - Intraoral and extraoral radiographic images
   - Oral/facial photographic images
   - Maxillofacial MRI, ultrasound
   - Cone beam image capture
   - Tests and Examinations
   - Viral culture
   - Collection and preparation of saliva sample for laboratory diagnostic testing
   - Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
   - Oral pathology laboratory
   - Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   - Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
Other oral pathology procedures, by report

**Preventive Services**

* Indicates services that can be covered every three (3) months for individuals with special healthcare needs.

a) Dental prophylaxis once every six (6) months*
b) Topical fluoride treatment once every six (6) months – in conjunction with prophylaxis as a separate service*
c) Fluoride varnish once every three (3) months for individuals under age six (6)
d) Sealants, limited to one (1) time application to all occlusal surfaces that are unfilled and carries free, in premolars and permanent molars.
e) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
   i) fixed – unilateral and bilateral
   ii) removable – bilateral only
   iii) recementation of fixed space maintainer
   iv) removal of fixed space maintainer when it was not placed by the same Dentist

**Restorative Services**

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Coverage includes the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- Coverage for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas are not covered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not covered.

Covered restorative services include:

a) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Coverage includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
b) Gold foil – Coverage includes local anesthesia, polishing and adjusting occlusion
c) Inlay/onlay restorations – metallic, coverage includes local anesthesia, cementation, polishing and adjusting occlusion
d) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function. Not covered if Cosmetic, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis. Coverage includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion. Provisional crowns are not covered.
e) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown
f) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Coverage includes local anesthesia, insertion with cementation and adjusting occlusion.
g) Core buildup, including pins
h) Pin retention
i) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
j) Additional fabricated (custom fabricated/cast) and prefabricated post
k) Post removal
l) Temporary crown (fractured tooth)
m) Additional procedures to construct new crown under existing partial denture
n) Coping
o) Crown repair
p) Protective restoration/sedative filling

Endodontic Services
- Coverage includes all necessary radiographs or views needed for endodontic treatment.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.

Covered endodontic services include:
- a) Therapeutic pulpotomy for primary and permanent teeth
- b) Pulpal debridement for primary and permanent teeth
- c) Partial pulpotomy for apexogenesis
- d) Pulpal therapy for anterior and posterior primary teeth
- e) Endodontic therapy and retreatment
- f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
- g) Apexification: initial, interim and final visits
- h) Pulpal regeneration
- i) Apicoectomy/Periradicular Surgery
- j) Retrograde filling
- k) Root amputation
- l) Surgical procedure for isolation of tooth with rubber dam
- m) Hemisection
- n) Canal preparation and fitting of preformed dowel or post
- o) Post removal

Periodontal Services
- a) Surgical services
  - i) Gingivectomy and gingivoplasty
  - ii) Gingival flap including root planning
  - iii) Apically positioned flap
  - iv) Clinical crown lengthening
  - v) Osseous surgery
  - vi) Bone replacement graft – first site and additional sites
  - vii) Biologic materials to aid soft and osseous tissue regeneration
  - viii) Guided tissue regeneration
  - ix) Surgical revision
  - x) Pedicle and free soft tissue graft
  - xi) Subepithelial connective tissue graft
  - xii) Distal or proximal wedge
  - xiii) Soft tissue allograft
  - xiv) Combined connective tissue and double pedicle graft
- b) Non-Surgical Periodontal Service
  - i) Provisional splinting – intracoronal and extracoronal – can be covered for treatment of dental trauma
  - ii) Periodontal root planing and scaling – can be covered every six (6) months for individuals with special healthcare needs
  - iii) Full mouth debridement to enable comprehensive evaluation
  - iv) Localized delivery of antimicrobial agents
c) Periodontal maintenance

Prosthodontic Services

- New dentures or replacement dentures may be considered every seven and a half (7 ½) years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for six (6) months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Covered prosthodontic services include:

a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight (8) posterior teeth (natural or prosthetic) resulting in balanced occlusion.
c) Resin base and cast frame dentures including any conventional clasps, rests and teeth
d) Flexible base denture including any clasps, rests and teeth. Removable unilateral partial dentures or dentures without clasps are not covered.
e) Overdenture – complete and partial
f) Denture adjustments – six (6) months after insertion or repair
g) Denture repairs – includes adjustments for first six (6) months following service
h) Denture rebase – following twelve (12) months post denture insertion and includes adjustments for first six (6) months following service.
i) Denture relines – following twelve (12) months post denture insertion denture relines are covered once per year and includes adjustments for first six (6) months following service
j) Precision attachment, by report
k) Maxillofacial prosthetics - includes adjustments for first six (6) months following service
l) Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
m) Obturator prosthesis: surgical, definitive and modifications
n) Mandibular resection prosthesis with and without guide flange
o) Feeding aid
p) Surgical stents
q) Radiation carrier
r) Fluoride gel carrier
s) Commissure splint
t) Surgical splint
u) Topical medicament carrier
v) Adjustments, modification and repair to a maxillofacial prosthesis
w) Maintenance and cleaning of maxillofacial prosthesis
x) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two (2) years. Covered services include: implant body, abutment and crown.
y) Fixed prosthodontics (fixed bridges) –limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists. Replacement of an existing defective fixed bridge or replacement of a
removable denture with a fixed bridge is allowed when an individual has special health needs that result in the inability to tolerate a removable denture.

**z)** Posterior fixed bridge is only covered for a unilateral case when there is masticatory deficiency due to fewer than eight (8) posterior teeth in balanced occlusion with natural or prosthetic teeth. Abutment teeth must be periodontally sound and have a good long term prognosis

**aa)** Repair and recementation

**bb)** Pediatric partial denture for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth.

**Oral and Maxillofacial Surgical Services**

**a)** Local anesthesia, suturing and routine post-op visit for suture removal are included with service.

**b)** Extraction of teeth:

i) Extraction of coronal remnants – deciduous tooth,

ii) Extraction, erupted tooth or exposed root

iii) Surgical removal of erupted tooth or residual root

iv) Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications

v) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.

**c)** Other surgical Procedures

i) Oroantral fistula

ii) Primary closure of sinus perforation and sinus repairs

iii) Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident

iv) Surgical access of an unerupted tooth

v) Mobilization of erupted or malpositioned tooth to aid eruption

vi) Placement of device to aid eruption

vii) Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy

viii) Surgical repositioning of tooth/teeth

ix) Transseptal fiberotomy/supra crestal fiberotomy

x) Surgical placement of anchorage device with or without flap

xi) Harvesting bone for use in graft(s)

xii) Alveoloplasty in conjunction or not in conjunction with extractions

xiii) Vestibuloplasty

xiv) Excision of benign and malignant tumors/lesions

xv) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies

xvi) Destruction of lesions by electrosurgery

xvii) Removal of lateral exostosis, torus palatinus or torus madibularis

xviii) Surgical reduction of osseous tuberosity

xix) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware by same Dentist.

xx) Surgical Incision

   (1) Incision and drainage of abcess - intraoral and extraoral

   (2) Removal of foreign body

   (3) Partial ostectomy/sequestrectomy

   (4) Maxillary sinusotomy

xxi) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware by same Dentist.

xxii) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJDS), with or without appliance. Includes placement or removal of appliance and/or hardware by same Dentist.
xxiii) Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware by same Dentist.

xxiv) Manipulation under anesthesia

xxv) Condylectomy, discectomy, synovectomy

xxvi) Joint reconstruction

xxvii) Arthroty, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage

xxviii) Arthroscopy

xxix) Occlusal orthotic device – includes placement and removal by same Dentist

xxx) Surgical and other repairs

(1) Repair of traumatic wounds – small and complicated
(2) Skin and bone graft and synthetic graft
(3) Collection and application of autologous blood concentrate
(4) Osteoplasty and osteotomy
(5) LeFort I, II, III with or without bone graft
(6) Graft of the mandible or maxilla – autogenous or nonautogenous
(7) Sinus augmentations
(8) Repair of maxillofacial soft and hard tissue defects
(9) Frenectomy and frenoplasty
(10) Excision of hyperplastic tissue and pericoronal gingiva
(11) Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
(12) Emergency tracheotomy
(13) Coronoidectomy
(14) Implant – mandibular augmentation purposes
(15) Appliance removal – “by report” for Dentist that did not place appliance, splint or hardware

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the individual.

• Orthodontic treatment requires prior authorization and is not considered for Cosmetic purposes.
• Orthodontic consultation can be provided once annually as needed by the same Dentist.
• Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for prior authorization.
• Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. Extractions should not be provided without proof of approval for orthodontic service.
• Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
• Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
• The placement of the appliance represents the treatment start date.
• Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for a Dentist that did not start case.
• Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Covered orthodontic services include:

a) Limited treatment for the primary, transitional and adult dentition
b) Interceptive treatment for the primary and transitional dentition  
c) Minor treatment to control harmful habits  
d) Continuation of transfer cases or cases started outside of the program  
e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.  
f) Orthognathic Surgical Cases with comprehensive orthodontic treatment  
g) Repairs to orthodontic appliances  
h) Replacement of lost or broken retainer  
i) Rebonding or recementing of brackets and/or bands  

**Adjunctive General Services**  
a) Palliative treatment for emergency treatment – per visit  
b) Anesthesia  
   i) Local anesthesia NOT in conjunction with operative or surgical procedures.  
   ii) Regional block  
   iii) Trigeminal division block  
   iv) Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Group Contract which requires hospitalization or general anesthesia. Two (2) hour maximum time  
   v) Intravenous conscious sedation/analgesia – Two (2) hour maximum time  
   vi) Nitrous oxide/analgesia  
   vii) Non-intravenous conscious sedation – to include oral medications  
c) Behavior management – for additional time required to provide services to a individual with special needs that requires more time than generally required to provide a dental service.  
   • One (1) unit equals fifteen (15) minutes of additional time  
   • Utilization thresholds are based on place of service as follows.  
     o Office or Clinic maximum – two (2) units  
     o Inpatient/Outpatient hospital – four (4) units  
     o Skilled Nursing/Long Term Care – two (2) units  
d) Consultation by specialist or non-primary care provider  
e) Professional visits  
   • House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.  
   • Hospital or ambulatory surgical center call  
     o For cases that are treated in a facility.  
     o For cases taken to the operating room – dental services are provided for patient with a medical condition covered by this Group Contract which requires this admission as in-patient or out-patient.  
     o General anesthesia and outpatient facility charges for dental services are covered  
     o Dental services rendered in these settings by a Dentist not on staff are covered separately  
   • Office visit for observation – (during regular hours) no other service performed  
f) Drugs  
   • Therapeutic parenteral drug  
     o Single administration  
     o Two or more administrations - not to be combined with single administration  
   • Other drugs and/or medicaments – by report  
g) Application of desensitizing medicament – per visit  
h) Occlusal guard – for treatment of bruxism, clenching or grinding  
i) Athletic mouthguard covered once per year  
j) Occlusal adjustment
• Limited - (per visit)
• Complete (regardless of the number of visits), once in a lifetime

k) Odontoplasty
l) Internal bleaching

**Predetermination**

A predetermination is a request for Us to estimate benefits for a dental treatment You have not yet received. Predetermination is not a guarantee of benefits or coverage. Predetermination is not required for any benefits under the Plan. In estimating benefits, We look at patient eligibility, Dental Necessity (See definition of Dentally Necessary above) and the Plan’s coverage for the treatment. Payment of benefits for a predetermined service is subject to Your continued eligibility in the Plan. At the time the claim is paid, We may also correct mathematical errors, apply coordination of benefits, and make adjustments to comply with Your current Plan and applicable Annual Maximums, Lifetime Maximums, or Out-of-Pocket Maximums on the date of service.

**Claim Forms**

The Company will provide You, the Member filing the claim, or Your Group with claim forms for filing a claim. The claim forms will be furnished to those Members who want to submit a claim that would have otherwise been submitted by their Dentist. If claim forms are not furnished within 15 days of the request, You will be deemed to have complied with the required time for filing a claim, upon submitting proof of the occurrence and a written statement of the nature and extent for which the claim is being made. Claims must be filed with the Company at its said office within 90 days after the period for which the Company is liable. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible. If You have not assigned Your rights to payment You shall receive payment within 40 days after filing a paper claim.

**Notice of Claim**

Electronic or written notice of claims must be given to the Company within 20 days after the occurrence or after the event on which the claim is based. Notice given by or on behalf of the Member to the Company, at the address referenced in the introductory section of this Certificate, which contains sufficient information to identify the Member, shall be deemed notice to the Company, if it was not reasonably possible to give written notice within the 20 day period. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

**Time Payment of Claims**

All benefits payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid no later than 30 days from receipt of due electronic proof of such loss or 40 days from receipt of due written proof of loss.

**Dental Examinations**

The Company at its own expense shall have the right and opportunity to examine You when and as often as it may reasonably be required during the pendency of a claim hereunder.
Payment of Benefits

If You have treatment performed by a Network Dentist, We will pay covered benefits directly to the Network Dentist. Both You and the Dentist will be notified of benefits covered, Our payment and any Out-of-Pocket Expenses. Payment will be based on the Maximum Allowable Charge Your Network Dentist has contracted to accept. Maximum Allowable Charges may vary depending on the geographical area of the dental office and the contract between Us and the particular Network Dentist rendering the service. Benefits for covered dental emergency services provided by a Non-Network Dentist will be paid at the same level that would have been paid had the services been rendered by a Network Dentist.

If You receive treatment from a Non-Network Dentist, We will send payment for Covered Services based on Out-of-Network Reimbursement Schedule Amounts to You unless the claim indicates that payment should be sent directly to Your treating Dentist. This is called assignment of benefits, and it is available for care delivered by Non-Network Dentists outside of Pennsylvania and West Virginia. You will be notified of the services covered, Our payment and any Out-of-Pocket Expenses. You will be responsible to pay the Dentist any difference between Our payment and the Dentist's full charge for the services. Non-Network Dentists are not obligated to limit their fees to Our Maximum Allowable Charges.

We are not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. Procedures started prior to the Member's Effective Date are the liability of the Member.

The Company does not disclose claim or eligibility records except as allowed or required by law and then in accordance with federal and state law. The Company maintains physical, electronic, and procedural safeguards to guard claims and eligibility information from unauthorized access, use, and disclosure.

Overpayments

When there is an overpayment for benefits, the overpayment may only be sought from the provider. We will recover the overpayment either by requesting a refund or offsetting the amount overpaid from future claim payments. This recovery will follow any applicable state laws or regulations. The provider must provide any assistance necessary, including furnishing information and signing necessary documents, for the Company to be reimbursed.

Coordination of Benefits (COB)

You may be covered for health benefits or services by more than one Plan. You may be covered by this Plan as an Employee and by another plan as a Dependent of a Spouse. If You are, this provision allows Us to coordinate what We pay or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which You are covered.

Definitions

The words shown below have special meanings when used in this provision. Please read these definitions carefully. Throughout this provision, these defined terms appear with their initial letter capitalized.
**Allowable Expense**: The charge for any health care service, supply or other item of expense for which You are liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this Plan is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

We will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is medically necessary and appropriate.

When this Plan is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, We will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

**Claim Determination Period**: A calendar year, or portion of a calendar year, during which You are covered by this Plan and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

**Plan**: Coverage with which coordination of benefits is allowed. Plan includes:

a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;
e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or nongovernmental plan.

Plan does not include:

a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by You except when coverage is being continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident –type coverage;
f) A State plan under Medicaid.

**Primary Plan**: A Plan whose benefits for Your health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either “a” or “b” below exist:

a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
b) All Plans which cover You use order of benefit determination rules consistent with those contained in this Coordination of Benefits and Services provision and under those rules, the Plan determines its benefits first.
**Reasonable and Customary:** An amount that is not more than the usual or customary charge for the service or supply as determined by Us, based on a standard which is most often charged for a given service by a provider within the same geographic area.

**Secondary Plan:** A Plan which is not a Primary Plan. If You are covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

**Primary and Secondary Plan:**
We consider each Plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the Plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each claim determination period, the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the Procedures to be Followed by the Secondary Plan to Calculate Benefits section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for medically necessary and appropriate services and supplies on the basis that precertification, prior approval, notification or second surgical opinion procedures were not followed.

**Rules For The Order of Benefit Determination:**
The benefits of the Plan that covers You as an employee, Member, subscriber or retiree shall be determined before those of the Plan that covers You as a Dependent. The coverage as an employee, Member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers You as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers You as a laid off or retired employee, or as such a person’s Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers You as an employee, Member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers You under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a individual is covered as a Dependent under Plans through both parents, and the parents are neither separated from a Civil Union or a dissolved domestic partnership, any other union described in the definition of Spouse nor divorced, the following rules apply:

a) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar year.
b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the parent for a shorter period of time.
c) Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
d) If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If an individual is covered as a Dependent under Plans through both parents, and the parents are separated from a Civil Union or a dissolved [domestic partnership], any other union described in the definition of Spouse or divorced, the following rules apply:
a) The benefits of the Plan of the parent with custody of the individual shall be determined first.
b) The benefits of the Plan of the Spouse of the parent with custody shall be determined second.
c) The benefits of the Plan of the parent without custody shall be determined last.
d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the individual, and if the entity providing coverage under that Plan has knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which Plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

**Procedures to be Followed by the Secondary Plan to Calculate Benefits:**
In order to determine which procedure to follow it is necessary to consider:
a) the basis on which the Primary Plan and the Secondary Plan pay benefits; and
b) whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary charge (R&C), or some similar term. This means that the provider bills a charge and You may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an “R&C Plan.”

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, You may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a “Fee Schedule Plan.” If You use the services of a nonnetwork provider, the Plan will be treated as an R&C Plan even though the Plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means that the health maintenance organization (HMO) or other Plan pays the provider a fixed amount per Member. You are liable only for the applicable deductible, coinsurance or copayment. If the You use the services of a Non-Network provider, the HMO or other Plan will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a “Capitation Plan.”

In the rules below, “provider” refers to the provider who provides or arranges the services or supplies and “HMO” refers to a health maintenance organization plan.
Primary Plan is R&C Plan and Secondary Plan is R&C Plan:
The Secondary Plan shall pay the lesser of:
a) the difference between the amount of the billed charges and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan. When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan:
If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) The amount the Secondary Plan would have paid if it had been the Primary Plan. The total amount the provider receives from the Primary Plan, the Secondary Plan and the Member shall not exceed the fee schedule of the Primary Plan. In no event shall the Member be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan:
If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:
a) the difference between the amount of the billed charges for the Allowable Charges and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan. You shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if You have no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the primary and Secondary Plans are less than the provider’s billed charges. In no event shall You be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan:
If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan:
If the Primary Plan is an HMO plan that does not allow for the use of Non-Network providers except in the event of urgent care or emergency care and the service or supply You receive from a Non-Network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan:
If You receive services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan:
If You receive services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the
deductible, coinsurance or copayment imposed by the Primary Plan. You shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

**Primary Plan is an HMO and Secondary Plan is an HMO:**
If the Primary Plan is an HMO plan that does not allow for the use of Non-Network providers except in the event of urgent care or emergency care and the service or supply You receive from a Non-Network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out of network services, if any, authorized by the Primary Plan.

**Workers’ Compensation**
When a Member is eligible for Workers’ Compensation benefits through employment, the cost of dental treatment for an injury which arises out of and in the course of Member’s employment is not a covered benefit under this Plan. Therefore, if the Company pays benefits which are covered by a Workers’ Compensation policy, the Company has the right to obtain reimbursement for those benefits paid. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the Company to receive the reimbursement.

**Review of a Benefit Determination**
If You are not satisfied with a benefit determination or payment, please contact Our Customer Service Department at the toll-free telephone number in the Introduction section of this Certificate or on Your ID card. If, after speaking with a Customer Service representative, You are still dissatisfied, refer to the Appeal Procedure Addendum attached to this Certificate for further steps You can take regarding Your claim.
TERMINATION- WHEN COVERAGE ENDS

[A Member’s coverage will end:

• when You no longer meet Your Group’s eligibility requirements; or
• when Premium payment ceases for You; or
• when You no longer meet the eligibility requirements for a Dependent, as defined in the Definitions section of this Certificate; or
• when You no longer meet other eligibility requirements imposed by the Company; or
• on the termination date specified for You by Company.

On the date the Certificate Holder’s coverage ends or the Certificate Holder is no longer eligible to enroll his/her Dependents, Dependent coverage will end unless otherwise specified in any applicable addendum or endorsement to this Certificate. If the Group Policy is cancelled, Certificate Holder and Dependent coverage (if applicable) will end on the Group Policy Termination Date.

If a Certificate Holder’s coverage ends during a time of disability, this Policy provides either an extension of three (3) months or an accrued liability for expenses incurred during the period of disability or during a period of at least three (3) months days starting with a specific event which occurred while coverage was in force (such as, an accident).

If the Policyholder fails to pay Premium, coverage will remain in effect during the Grace Period. If the Premium is not received by the end of the Grace Period, the Group Policy will be cancelled and coverage will terminate on the last date for which Premium was paid.

Benefits After Coverage Terminates

We are not liable to pay any benefits for services, including those predetermined that are started after Your Termination Date or after the Group Policy Termination Date. However, coverage for completion of a dental procedure requiring two (2) or more visits on separate days will be extended for a period of ninety (90) days after the Termination Date in order for the procedure to be finished. The procedure must be started prior to the Termination Date. The procedure is considered “started” when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member’s Termination Date. This extension does not apply if the Group Policy terminates for failure to pay Premium.

CONTINUATION COVERAGE

Federal or state law may require that certain employers offer continuation coverage to Members for a period of time upon the Certificate Holder’s reduction of work hours or termination of employment for any reason other than gross misconduct. Contact Your Group to find out if this applies to You. Your Group will advise You of Your rights to continuation coverage and the cost. If applicable, You must elect to continue coverage within sixty (60) days from Your qualifying event or from notification of rights by Your Group, whichever is later. Dependents may have separate election rights, or You may elect to continue coverage for them. You must pay the required premium for continuation coverage directly to Your Group. The Company is not responsible for determining who is eligible for continuation coverage.
GENERAL PROVISIONS

The failure of any section or subsection of this Certificate shall not affect the validity, legality and enforceability of the remaining sections.

Except as otherwise herein provided, this Certificate may be amended, changed or modified only in writing and thereafter attached hereto as part of this Certificate.

The Company may assign this Certificate and its rights and obligations hereunder to any entity under common control with the Company.

This Certificate will be construed for all purposes as a legal document and will be interpreted and enforced in accordance with pertinent laws and regulations of the state indicated on the State Law Provisions Addendum.

No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of 60 days after claims have been filed in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of 3 years after the time a claim is required to be filed.
ADDENDUM TO CERTIFICATE

APPEAL PROCEDURE

This Addendum is effective on the Effective Date stated in the Group Policy. It is attached to and made part of the Certificate.

If you are dissatisfied with our benefit determination on a claim, you or your authorized representative may appeal our decision by following the steps outlined in this procedure. We will resolve your appeal in a thorough, appropriate, and timely manner to ensure that you are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the Plan documents and consistently among claimants. You or your authorized representative may submit written comments, documents, records, and other information relating to claims or appeals. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by us required under these procedures will be supplied to you or your authorized representative.

DEFINITIONS

The following terms when used in this document have the meanings shown below.

“Adverse Benefit Determination” is a denial, reduction, or termination of or failure to make payment (in whole or in part) for a Claim for Benefits based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is Experimental or Investigational, not Dentally Necessary, not Medically Necessary or not appropriate.

“Authorized Representative” is a person granted authority by you and the company to act on your behalf regarding a Claim for Benefits or an appeal of an Adverse Benefit Determination. An assignment of benefits is not a grant of authority to act on your behalf in pursuing and appealing a benefit determination.

“Claim for Benefits” is a request for a plan benefit or benefits by you in accordance with the Plan’s reasonable procedure for filing benefit claims, including Pre-service and Post-service Claims.

“Pre-service Claim” is a Claim for Benefits under the Plan when the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

“Post-service Claim” (“Claim”) is any Claim for Benefits under a group health plan that is not a Pre-service Claim.

“Relevant” A document, record, or other information will be considered “relevant” to a given claim:

a) if it was relied on in making the benefit determination;
b) if it was submitted, considered, or generated in the course of making the benefit determination (even if the Plan did not rely on it);
c) if it demonstrated that, in making the determination, the Plan followed its own administrative processes and safeguards for ensuring appropriate decision-making and consistency;
d) or if it is a statement of the Plan’s policy or guidance concerning the denied benefit, without regard to whether it was relied upon in making the benefit determination.

**PROCEDURE FOR PRE-SERVICE CLAIM**

You or Your Authorized Representative have 180 days from the date You or Your Authorized Representative received notice of the Adverse Benefit Determination to appeal the decision. To file an appeal, call the toll-free telephone number listed in Your Certificate of Coverage or on Your ID card.

The dentist advisor involved in the appeal will be different from and not a subordinate of the dentist advisor involved in the adverse determination on initial Claim for Benefits. We will provide You or Your Authorized Representative with written or electronic notice of Our appeal decision within 30 days of the request to review the Adverse Benefit Determination. The notice of Our appeal decision will include the following:

a) The specific reason for the appeal decision;
b) A reference to specific plan provisions on which the decision was based;
c) A statement that You or Your Authorized Representative is entitled reasonable access to and copies of all relevant documents, records, and criteria. This includes an explanation of clinical judgment on which the decision was based and identification of the dental experts. All such information is available upon request and is free of charge.
d) A statement of Your or Your Authorized Representative’s right to bring a civil action under ERISA; and
e) The following statement: “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.”

**PROCEDURE FOR POST-SERVICE CLAIM**

You or Your authorized representative may file an appeal with Us within 180 days of receipt of an adverse benefit determination. To file an appeal, telephone the toll-free number listed in Your Certificate of Insurance or on Your ID card.

We will review the claim and notify You of Our decision within 60 days of the request for appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination.

Notice of the appeal decision will include the following in written or electronic form:

a) the specific reason for the appeal decision;
b) reference to specific plan provisions on which the decision was based;
c) a statement that You are entitled to receive upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts; All such information is available upon request and is free of charge.

d) a statement of Your right to bring a civil action under ERISA; and

e) the following statement: “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.”
COMPLAINTS

You or Your authorized representative may submit complaints to the Department of Banking and Insurance (DOBI) or the Office of Insurance Claims Ombudsman. Complaints should be based on questions that have to do with the nature of the benefits that are described in the policy, such as procedures that are covered or not covered, frequency limits, timely premium payments, and eligibility and may be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
P.O. Box 329
Trenton, New Jersey 08625-0329

OR

Office of Insurance Claims Ombudsman
20 West State Street
P.O. Box 472
Trenton, NJ 08625-0472
Phone: 800-446-7467 (TTY: 711)
( outside of NJ call 609-292-5316 & ask for the Ombudsman’s Office)
Fax: 609-292-2431
Email: ombudsman@dobi.state.nj.us

Any denials that are based upon medical judgement, such as medical necessity or experimental and Investigational, should be submitted to Us. Do not send them to the New Jersey addresses above.
AmeriHealth Insurance Company of New Jersey

Schedule of Benefits

THIS PLAN MEETS THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

THE PEDIATRIC CHILD BENEFITS ARE ONLY AVAILABLE FOR INDIVIDUALS THROUGH THE END OF THE CONTRACT YEAR THAT THEY TURN 19.

This Policy will pay benefits for Covered Services shown below subject to the Schedule of Exclusions and Limitations and other Policy terms. Payment is based on the Maximum Allowable Charge (MAC) for the specific Covered Service. Network Dentists accept contracted MACs as payment in full for Covered Services. Network Dentists may also agree to limit their charges for any other services delivered to Members.

Non-Network Dentists do not limit their charges and may bill You for the difference between their charge and the benefit paid by the Policy.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Benefits for Dental Service Category</th>
<th>Waiting Period</th>
<th>Policy Pays for Adult</th>
<th>After Deductible</th>
<th>if Adult</th>
<th>If Certified Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Evaluations (Exams)</td>
<td>Diagnostic Services For individual</td>
<td>None</td>
<td>100%</td>
<td>90%</td>
<td>N/A</td>
<td>No</td>
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<tr>
<td>Radiographs (All X-Rays)</td>
<td>Preventive Services For individual</td>
<td>None</td>
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<td>50%</td>
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<tr>
<td>Prophylaxis (Cleanings)</td>
<td>Preventive Services For individual</td>
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<td>90%</td>
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<tr>
<td>Fluoride Treatments</td>
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<td></td>
<td>100%</td>
<td>90%</td>
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<tr>
<td>Space Maintainers</td>
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<td>100%</td>
<td>90%</td>
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<tr>
<td>Sealants</td>
<td></td>
<td></td>
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<td>90%</td>
<td>N/A</td>
<td>No</td>
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<tr>
<td>Basic Restoration Anterior Composite</td>
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<td></td>
<td>100%</td>
<td>90%</td>
<td>N/A</td>
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<tr>
<td>Basic Restoration Anterior Amalgam</td>
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<td></td>
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<td>90%</td>
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<tr>
<td>Basic Restoration Posterior Amalgam</td>
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<td></td>
<td>100%</td>
<td>90%</td>
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<table>
<thead>
<tr>
<th>Contract Year Deductible per Insured for Pediatric Benefits:</th>
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</thead>
<tbody>
<tr>
<td>Contract Year Deductible per Insured Adult:</td>
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</tr>
<tr>
<td>Annual Maximum per Insured Adult:</td>
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<tr>
<td>Out-of-Pocket Maximum for Certificate Holders Covering One (1) Insured Pediatric:</td>
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</tr>
<tr>
<td>Out-of-Pocket Maximum for Certificate Holders Covering Two (2) or More Insured:</td>
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<tr>
<td>Service</td>
<td>Coverage</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>----------</td>
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<td>Crowns, Inlays, Onlays</td>
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<tr>
<td>Crown Repair</td>
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<td>Endodontic Therapy (Root canals,)</td>
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</tr>
<tr>
<td>Endodontic Services</td>
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<tr>
<td>Surgical Periodontics</td>
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<tr>
<td>Non-Surgical Periodontics</td>
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<tr>
<td>Periodontal Maintenance</td>
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<tr>
<td>Prosthodontic (Fixed Partial Dentures)</td>
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<tr>
<td>Prosthodontic Services</td>
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<tr>
<td>Prosthetics (Complete Partial Dentures)</td>
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<tr>
<td>Adjustments and Repairs of Prosthetics</td>
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<tr>
<td>Maxillofacial Prosthetics</td>
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</tr>
<tr>
<td>Implant Services</td>
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</tr>
<tr>
<td>Simple Extractions</td>
<td>None</td>
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<tr>
<td>Surgical Extractions</td>
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</tr>
<tr>
<td>Oral Surgery</td>
<td>None</td>
</tr>
<tr>
<td>Apicoectomy/Periradicular Surgery</td>
<td>None</td>
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<tr>
<td>General Anesthesia, Nitrous Oxide and/or IV Sedation</td>
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<tr>
<td>Consultations</td>
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<td>Palliative Treatment (Emergency)</td>
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<tr>
<td>Medically Necessary Orthodontics</td>
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</tr>
<tr>
<td>Cosmetic Orthodontic Services</td>
<td>None</td>
</tr>
</tbody>
</table>
**Medically Necessary Orthodontics Coverage:**

In this section, "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician or Dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. in accordance with the generally accepted standards of medical/dental practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. not primarily for the convenience of the patient or physician/Dentist, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

As used subpart 1, above, "generally accepted standards of medical/dental practice" means:
- standards that are based on credible scientific evidence published in peer-reviewed, medical/dental literature generally recognized by the relevant professional community;
- recognized Medical/Dental and Specialty Society recommendations;
- the views of physicians/Dentists practicing in the relevant clinical area; and
- any other relevant factors.

A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the individual.

**Coverage of Medically Necessary Orthodontics:**

1. Orthodontic treatment must be Medically Necessary and be the only method capable of:
   a) Preventing irreversible damage to the Member’s teeth or their supporting structures and,
   b) Restoring the Member’s oral structure to health and function.

2. Members must have a fully erupted set of permanent teeth to be eligible for comprehensive, Medically Necessary orthodontic services for handicapping malocclusions of the adult dentition.

3. Other orthodontic Covered Services include: pre-orthodontic treatment visit for completion of HLD (NJ-Mod2) form, diagnostic photographs and panoramic radiographs; limited treatment for the primary, transitional and adult dentition; interceptive treatment for the primary transitional dentition; minor treatment to control harmful habits; continuation of transfer cases or cases started prior to the Member’s Effective Date; orthognathic surgical cases with comprehensive orthodontic treatment; placement and removal of orthodontic appliances; repairs to orthodontic appliances; replacement of lost or broken retainer; rebonding or recementing of brackets and/or bands; and removal of appliances by a provider that did not start the case when requested by report.

4. **All Medically Necessary orthodontic services require prior approval** and a written plan of care.

Please review your Certificate Booklet section concerning Orthodontic Services for specific benefit information.
THIS PLAN MEETS THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

THIS SCHEDULE APPLIES ONLY TO COVERAGE FOR CHILDREN THROUGH THE END OF THE CONTRACT YEAR THAT THEY TURN 19.

EXCLUSIONS – Only American Dental Association procedure codes are covered. Exclusion and limitations may differ by state as specified below. Except as specifically provided in the Certificate, Schedules of Benefits, and Riders, no coverage will be provided for services, supplies or charges that are:

1. Started prior to the Member’s Effective Date or after the Termination Date of coverage under the Group Policy, including, but not limited to multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures.

2. The responsibility of Workers’ Compensation or employer’s liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company’s benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

3. For prescription and non-prescription drugs, vitamins or dietary supplements.

4. Cosmetic in nature as determined by the Company (for example but not limitation, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures). This exclusion does not apply for Cosmetic services for newly born Dependents.

5. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).

6. For services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

7. For replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

8. For prefabricated or temporary dentures

9. For which in the absence of insurance the Member would incur no charge.

10. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

11. For any claims submitted to the Company by the Member or on behalf of the Member in excess of ninety (90) days after the date of service. Failure to submit the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time and the claim is furnished as soon as reasonably possible.

12. For incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).

13. For procedures that are:
   - part of a service but are reported as separate services; or
   - reported in a treatment sequence that is not appropriate; or
• misreported or that represent a procedure other than the one reported.

14. For specialized procedures and techniques (for example but not limitation, precision attachments and intentional root canal treatment).

15. Fees for broken appointments.

16. Those specifically listed on the Schedule of Benefits as “Not Covered” or “Plan Pays 0%”.

17. Not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.

18. Orthodontic treatment is not a Covered Service unless deemed Medically Necessary and a written treatment plan is approved by Us.

Orthodontic services for the following are excluded:
• Treatments that are primarily for Cosmetic reasons;
• Orthodontic treatment provided after the end of the Contract Year that the child turns age 19, and treatment provided more than one month after termination of coverage under this Group Contract
• Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Schedule of Benefits. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

LIMITATIONS – Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age. All benefits under this plan end at the end of the Contract Year in which the child turns age 19.

1. Full mouth x-rays – one (1) every three (3) year(s). The number of films/views expected is based on age with the maximum being 16 intraoral films/views.

2. Diagnostic casts – for diagnostic purposes only and not in conjunction with other services

3. Oral pathology laboratory:
   • Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   • Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   • Other oral pathology procedures, by report

4. Oral Evaluations: Comprehensive, periodic and limited problem focused – one (1) of these services per six (6) months. One (1) of these services per three (3) months for Members with special healthcare needs.

5. Consultations – one (1) of these services per Dentist per patient per twelve (12) months for a consultant other than a Pedodontist or Orthodontist.

6. Detailed problem focused – one (1) per Dentist per patient per twelve (12) months per eligible diagnosis and one (1) per Dentist per patient per three (3) months for Members with special healthcare needs.

7. Prophylaxis – one (1) per six (6) months. One (1) additional for Members under the care of a medical professional during pregnancy. One (1) per three (3) months for Members with special healthcare needs.

8. Topical fluoride treatment – one (1) per six (6) months – in conjunction with prophylaxis as a separate service.
9. Fluoride varnish – one (1) per three (3) months for children under age six (6)

10. Sealants – limited to one (1) time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.

11. Periodontal Services:
   - Periodontal scaling and root planing – one (1) per thirty-six (36) months per area of the mouth. Individuals with special healthcare needs may be eligible every six (6) months.
   - Provisional Splinting (intracoronal and extracoronal) – Can be considered for treatment of dental trauma

12. Prosthodontics Service –
   a) New dentures or replacement dentures may be considered every seven and a half years (7 ½) unless dentures become obsolete due to additional extractions or are damaged beyond repair
   b) All needed dental treatment must be completed prior to denture fabrication.
      - Patient identification must be placed in dentures in accordance with State Board regulation.
      - Insertion of dentures includes adjustments for 6 months post insertion.
      - Prefabricated dentures or transitional dentures that are temporary in nature are not covered.
      - Subsequent denture relining or rebasing limited to one (1) every one (1) year thereafter.
   c) Denture Adjustment – six (6) months after insertion or repair
   d) Denture Repairs – Includes adjustments for first six (6) months following service
   e) Denture Rebase – Following twelve (12) months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first six (6) months following service
   f) Denture Relines – Following twelve (12) months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service.

13. Anesthesia
   a. Local anesthesia NOT in conjunction with operative or surgical procedures.
   b. Regional block
   c. Trigeminal division block.
   d. Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires hospitalization or general anesthesia. 2 hour maximum time
   e. 5. Intravenous conscious sedation/analgesia – 2 hour maximum time
   f. 6. Nitrous oxide/analgesia
   g. 7. Non-intravenous conscious sedation – to include oral medications

14. Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
   - One unit equals 15 minutes of additional time
   - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
     - Office or Clinic maximum – 2 units
     - Inpatient/Outpatient hospital – 4 units
     - Skilled Nursing/Long Term Care – 2 units

15. Maxillofacial prosthetics - includes adjustments for first 6 months following service:
a. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
b. Obturator prosthesis: surgical, definitive and modifications
c. Mandibular resection prosthesis with and without guide flange
d. Feeding aid
e. Surgical stents
f. Radiation carrier
g. Fluoride gel carrier
h. Commissure splint
i. Surgical splint
j. Topical medicament carrier
k. Adjustments, modification and repair to a maxillofacial prosthesis
l. Maintenance and cleaning of maxillofacial prosthesis

16. Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two (2) years. Covered services include: implant body, abutment and crown.

17. Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.

18. Therapeutic drug injections – only covered in unusual circumstances, by report.

19. Orthodontic Services – Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child. HLD (NJ-Mod2) assessment score must be at least equal to twenty-six (26) to qualify for coverage of comprehensive treatment for handicapping malocclusions of adult dentition.

a. Orthodontic consultation can be provided once annually by the same provider, if necessary.
b. Approval for comprehensive treatment is limited to twelve (12) visits per treatment plan. Additional visits may be approved if additional treatment plans are submitted with diagnostic tools that demonstrate progression of treatment.
c. Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided.
d. Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to the patient's nineteenth (19th) birthday.
e. Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment
f. The placement of appliance represents the treatment start date.
g. Removal of appliances can be requested by report as separate service for provider that did not start case.
h. Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.

20. Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.

21. Professional visits

22. House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
a. Hospital or ambulatory surgical center call
   i. For cases that are treated in a facility.

b. For cases taken to the operating room – dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.

c. General anesthesia and outpatient facility charges for dental services are covered

d. Dental services rendered in these settings by a dentist not on staff are considered separately

23. Occlusal guard – one (1) per year.
24. Athletic mouthguard – one (1) per year
25. Plaque control programs, tobacco counseling, oral hygiene and dietary instructions – covered by report
Schedule of Exclusions and Limitations

THIS PLAN DOES NOT MEET THE MINIMUM ESSENTIAL HEALTH BENEFIT
REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE
FEDERAL AFFORDABLE CARE ACT.

THIS SCHEDULE APPLIES ONLY TO COVERAGE FOR INDIVIDUALS AGES 19 AND
OLDER.

This Schedule describes services, supplies or charges that are excluded from coverage
(Exclusions), or for which coverage is limited by age or frequency (Limitations), subject to any
applicable provisions in the State Law Provisions Addendum attached to the Certificate. Only
American Dental Association procedure codes may be billed under this Policy.

EXCLUSIONS – The following services, supplies or charges are excluded:

1. Started prior to the Member’s Effective Date or after the Termination Date of coverage
   under the Policy (for example but not limitation, multi-visit procedures such as
   endodontics, crowns, fixed partial dentures, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
3. That are the responsibility of Workers’ Compensation or employer’s liability insurance, or for
   treatment of any automobile-related injury in which the Member is entitled to payment under
   an automobile insurance policy. The Company’s benefits would be in excess to the third-party
   benefits and therefore, the Company would have right of recovery for any benefits paid in
   excess.
4. For prescription and non-prescription drugs, vitamins or dietary supplements.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the
   Schedule of Benefits.
6. Which are Cosmetic in nature as determined by the Company (for example but not
   limitation, bleaching, veneer facings, personalization or characterization of crowns, fixed
   partial dentures and/or dentures).
7. Elective procedures (for example but not limitation, the prophylactic extraction of third
   molars).
8. For congenital mouth malformations or skeletal imbalances (for example but not limitation,
   treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the
   result of orthognathic surgery including orthodontic treatment).
9. For dental implants and any related surgery, placement, restoration, prosthetics
   (except single implant crowns), maintenance and removal of implants unless
   specifically indicated on the Schedule of Benefits.
10. Diagnostic services and treatment of jaw joint problems by any method unless specifically
    covered under the Policy.
    Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and
    craniomandibular disorders or other conditions of the joint linking the jaw bone and the
    complex of muscles, nerves and other tissues related to the joint.
11. For treatment of fractures and dislocations of the jaw.
12. For treatment of malignancies or neoplasms.
13. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

15. Preventive restorations.


17. For duplicate dentures, prosthetic devices or any other duplicative device.

18. For which in the absence of insurance the Member would incur no charge.

19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

21. For treatment and appliances for bruxism (night grinding of teeth).

22. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.

23. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).

24. Procedures that are:
   - part of a service but are reported as separate services
   - reported in a treatment sequence that is not appropriate
   - misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (for example but not limitation, precision attachments and intentional root canal treatment).

26. Fees for broken appointments.

27. Those specifically listed on the Schedule of Benefits as “Not Covered” or “Plan Pays 0%”.

28. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.

29. For space maintainers, fluoride treatment, sealants, and prefabricated stainless steel crowns.

LIMITATIONS – Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays – one (1) every five (5) years.

2. Bitewing x-rays – one (1) set per twelve (12) months up to age nineteen (19) and one (1) set per eighteen (18) months ages nineteen (19) and older.
3. Oral Evaluations:
   - Comprehensive and periodic – two (2) of these services per twelve (12) months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more years.
   - Limited problem focused and consultations – one (1) of these services per dentist per patient per twelve (12) months.
   - Detailed problem focused – one (1) per dentist per patient per twelve (12) months per eligible diagnosis.

4. Prophylaxis – two (2) per twelve (12) months. One (1) additional for Member under the care of a medical professional during pregnancy.

5. Periodontal Services:
   - Full mouth debridement – one (1) per lifetime.
   - Periodontal maintenance following active periodontal therapy – two (2) per twelve (12) months in addition to routine prophylaxis.
   - Periodontal scaling and root planing – one (1) per thirty-six (36) months per area of the mouth.
   - Surgical periodontal procedures – one (1) per thirty-six (36) months per area of the mouth.
   - Guided tissue regeneration – one (1) per tooth per lifetime.

6. Replacement of restorative services only when they are not, and cannot be made, serviceable:
   - Basic restorations – not within twenty-four (24) months of previous placement of any basic restoration.
   - Single crowns, inlays, onlays – not within five (5) years of previous placement of any procedures in this category.
   - Buildups and post and cores – not within five (5) years of previous placement of any procedures in this category.
   - Replacement of natural tooth/teeth in an arch – not within five (5) years of a fixed partial denture, full denture or partial removable denture.

7. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within six (6) months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every three (3) years thereafter.

8. Pulpal therapy - one (1) per eligible tooth per lifetime only when there is no permanent tooth to replace it. Eligible teeth limited to primary anterior teeth and primary posterior molars.

9. Root canal retreatment – one (1) per tooth per lifetime.

10. Recementation – one (1) per thirty-six (36) months. Recementation during the first twelve (12) months following insertion of any preventive, restorative or prosthodontics service by the same dentist is included in the preventive, restorative or prosthodontics service benefit.
11. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed under this ABP. This limitation does not apply to covered implantology services.

12. Implantology services, if covered on the Schedule of Benefits or by a Rider, are limited to one (1) per tooth per lifetime.

13. Intraoral films:
   - Periapical – four (4) per 12 months.

14. General anesthesia and IV sedation limited to sixty (60) minutes per session.
The Premium is determined as the sum of the per member per month base rate, based on age, for each enrolled Certificate Holder and/or Dependent as described below.

Premium stated below for the Policyholder's Certificate Holders and/or Dependents if applicable is due on the due date as specified on each notice of Premium and is guaranteed for the term stated below.

<table>
<thead>
<tr>
<th>Rating Age</th>
<th>Rate Per Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 18</td>
<td>$</td>
</tr>
<tr>
<td>19 and over</td>
<td>$</td>
</tr>
</tbody>
</table>

The Premium rates are guaranteed for the Group's Contract Year (12 month period beginning on Group's Anniversary Date).

AmeriHealth has the right to prospectively change any premium rate(s) set forth above at the times and in the manner established by the General Policy Rules – Term of the Group Policy.
AmeriHealth\(^2\) values you as a customer, and protection of your privacy is very important to us. In conducting our business, we will create and maintain records that contain protected health information about you and the health care provided to you as a member of our health plans.

**Note:** “Protected health information” or “PHI” is information about you, including information that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We protect your privacy by:

- limiting who may see your PHI;
- limiting how we may use or disclose your PHI;
- informing you of our legal duties with respect to your PHI;
- explaining our privacy policies; and
- adhering to the policies currently in effect.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members’ protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We also are required by the federal Health Insurance Portability and Accountability Act (or

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\(^1\) If you are enrolled in a self-insured group benefit program, this Notice is not applicable. If you are enrolled in such a program, you should contact your Group Benefit Manager for information about your group’s privacy practices. If you are enrolled in the Federal Employee’s Service Benefit Plan, you will receive a separate Notice.

\(^2\) For purposes of this Notice, “AmeriHealth” refers to the following companies: AmeriHealth HMO, Inc., AmeriHealth Insurance Company of New Jersey, and QCC Insurance Company d/b/a AmeriHealth Insurance Company.
HIPAA”) Privacy Rule to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

This revised Notice takes effect on September 23, 2013, and will remain in effect until we replace or modify it.

Copies of this Notice
You may request a copy of our Notice at any time. If you want more information about our privacy practices, or have questions or concerns, please contact Member Services by calling the telephone number on the back of your Member Identification Card, or contact us using the contact information at the end of this Notice.

Changes to this Notice
The terms of this Notice apply to all records that are created or retained by us which contain your PHI. We reserve the right to revise or amend the terms of this Notice. A revised or amended Notice will be effective for all of the PHI that we already have about you, as well as for any PHI we may create or receive in the future. We are required by law to comply with whatever Privacy Notice is currently in effect. You will be notified of any material change to our Privacy Notice before the change becomes effective. When necessary, a revised Notice will be mailed to the address that we have on record for the contract holder of your member contract, and will also be posted on our web site at www.amerihealth.com.

Potential Impact of State Law
The HIPAA Privacy Rule generally does not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

How We May Use and Disclose Your Protected Health Information (PHI)
In order to administer our health benefit programs effectively, we will collect, use and disclose PHI for certain of our activities, including payment of covered services and health care operations.

The following categories describe the different ways in which we may use and disclose your PHI. Please note that every permitted use or disclosure of your PHI is not listed below. However, the different ways we will, or might, use or disclose your PHI do fall within one of the permitted categories described below.

Treatment: We may disclosure information to doctors, pharmacies, hospitals and other health care providers who take care of you to assist in your treatment or the coordination of your care.

Payment: We may use and disclose your PHI for all payment activities including, but not limited to, collecting premiums or to determine or fulfill our responsibility to provide health care coverage under our health plans. This may include coordinating benefits with other health care programs or insurance carriers, such as Medicare or Medicaid. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors or hospitals which are covered by your health plan(s), or
to determine if requested services are covered under your health plan. We may also use and disclose your PHI to conduct business with other AmeriHealth affiliate companies.

**Health Care Operations:** We may use and disclose your PHI to conduct and support our business and management activities as a health insurance issuer. For example, we may use and disclose your PHI to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to conduct business planning activities, to conduct fraud detection programs, to conduct or arrange for medical review, or to engage in care coordination of health care services.

We may also use and disclose your PHI to offer you one of our value added programs like smoking cessation or discounted health related services, or to provide you with information about one of our disease management programs or other available AmeriHealth health products or health services.

We may also use and disclose your PHI to provide you with reminders to obtain preventive health services, and to inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.

**Marketing:** Your PHI will not be sold, used or disclosed for marketing purposes without your authorization except where permitted by law. Such exceptions may include: a marketing communication to you that is in the form of (a) a face-to-face communication, or (b) a promotional gift of nominal value.

**Release of Information to Plan Sponsors:** Plan sponsors are employers or other organizations that sponsor a group health plan. We may disclose PHI to the plan sponsor of your group health plan as follows:

- We may disclose “summary health information” to your plan sponsor to use to obtain premium bids for providing health insurance coverage or to modify, amend or terminate its group health plan. “Summary health information” is information that summarizes claims history, claims expenses, or types of claims experience for the individuals who participate in the plan sponsor’s group health plan;
- We may disclose PHI to your plan sponsor to verify enrollment/disenrollment in your group health plan;
- We may disclose your PHI to the plan sponsor of your group health plan so that the plan sponsor can administer the group health plan; and
- If you are enrolled in a group health plan, your plan sponsor may have met certain requirements of the HIPAA Privacy Rule that will permit us to disclose PHI to the plan sponsor. Sometimes the plan sponsor of a group health plan is the employer. In those circumstances, we may disclose PHI to your employer. You should talk to your employer to find out how this information will be used.

**Research:** We may use or disclose your PHI for research purposes if certain conditions are met. Before we disclose your PHI for research purposes without your written permission, an Institutional Review Board (a board responsible under federal law for reviewing and approving research involving human subjects) or Privacy Board reviews the research proposal to ensure that the privacy of your PHI is protected, and to approve the research.
**Required by Law:** We may disclose your PHI when required to do so by applicable law. For example, the law requires us to disclose your PHI:

- When required by the Secretary of the U.S. Department of Health and Human Services to investigate our compliance efforts; and
- To health oversight agencies, to allow them to conduct audits and investigations of the health care system, to determine eligibility for government programs, to determine compliance with government program standards, and for certain civil rights enforcement actions.

**Public Health Activities:** We may disclose your PHI to public health agencies for public health activities that are permitted or required by law, such as to:

- prevent or control disease, injury or disability;
- maintain vital records, such as births and deaths;
- report child abuse and neglect;
- notify a person about potential exposure to a communicable disease;
- notify a person about a potential risk for spreading or contracting a disease or condition;
- report reactions to drugs or problems with products or devices;
- notify individuals if a product or device they may be using has been recalled; and
- notify appropriate government agency(ies) and authority(ies) about the potential abuse or neglect of an adult patient, including domestic violence.

**Health Oversight Activities:** We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Health oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

**Lawsuits and Other Legal Disputes:** We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process once we have met all administrative requirements of the HIPAA Privacy Rule.

**Law Enforcement:** We may disclose your PHI to law enforcement officials under certain conditions. For example, we may disclose PHI:

- to permit identification and location of witnesses, victims, and fugitives;
- in response to a search warrant or court order;
- as necessary to report a crime on our premises;
- to report a death that we believe may be the result of criminal conduct; or
- in an emergency, to report a crime.

**Coroners, Medical Examiners, or Funeral Directors:** We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties.

**Organ and Tissue Donation:** We may use or disclose your PHI to organizations that handle organ and tissue donation and distribution, banking, or transplantation.
To Prevent a Serious Threat to Health or Safety: As permitted by law, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Military and National Security: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counter-intelligence, and other national security activities.

Inmates: If you are a prison inmate, we may disclose your PHI to the prison or to a law enforcement official for: (1) the prison to provide health care to you; (2) your health and safety, and the health and safety of others; or (3) the safety and security of the prison.

Underwriting: We will not use genetic information about you for underwriting purposes.

Workers' Compensation: As part of your workers’ compensation claim, we may have to disclose your PHI to a worker's compensation carrier.

To You: When you ask us to, we will disclose to you your PHI that is in a “designated record set.” Generally, a designated record set contains medical, enrollment, claims and billing records we may have about you, as well as other records that we use to make decisions about your health care benefits. You can request the PHI from your designated record set as described in the section below called “Your Privacy Rights Concerning Your Protected Health Information.”

To Your Personal Representative: If you tell us to, we will disclose your PHI to someone who is qualified to act as your personal representative according to any relevant state laws. In order for us to disclose your PHI to your personal representative, you must send us a completed AmeriHealth Personal Representative Designation Form or documentation that supports the person’s qualification according to state law (such as a power of attorney or guardianship). To request the AmeriHealth Personal Representative Designation Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.amerihealth.com, or write us at the address at the end of this Notice. However, the HIPAA Privacy Rule permits us to choose not to treat that person as your personal representative when we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse or neglect by the person; (ii) treating the person as your personal representative could endanger you; or (iii) in our professional judgment, it is not in your best interest to treat the person as your personal representative.

To Family and Friends: Unless you object, we may disclose your PHI to a friend or family member who has been identified as being involved in your health care. We also may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your PHI, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

Parents as Personal Representatives of Minors: In most cases, we may disclose your minor child’s PHI to you. However, we may be required to deny a parent’s access to a minor’s PHI according to applicable state law.
Right to Provide an Authorization for Other Uses and Disclosures

- Other uses and disclosures of your PHI that are not described above will be made only with your written authorization.
- You may give us written authorization permitting us to use your PHI or disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your PHI that are not identified by this Notice, or are not otherwise permitted by applicable law.

Any authorization that you provide to us regarding the use and disclosure of your PHI may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Of course, we are unable to take back any disclosures that we have already made with your authorization. We may also be required to disclose PHI as necessary for purposes of payment for services received by you prior to the date when you revoked your authorization.

Your authorization must be in writing and contain certain elements to be considered a valid authorization. For your convenience, you may use our approved AmeriHealth Authorization Form. To request the AmeriHealth Authorization Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.amerihealth.com, or write us at the address at the end of this Notice.

Your Privacy Rights Concerning Your Protected Health Information (PHI)

You have the following rights regarding the PHI that we maintain about you. Requests to exercise your rights as listed below must be in writing. For your convenience, you may use our approved AmeriHealth form(s). To request a form, please contact Member Services at the telephone number listed on the back of your Member Identification card or write to us at the address listed at the end of this Notice.

Right to Access Your PHI: You have the right to inspect or get copies of your PHI contained in a designated record set. Generally, a “designated record set” contains medical, enrollment, claims and billing records we may have about you, as well as other records that we may use to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies of your PHI in a format other than photocopies such as by electronic means in certain situations. We will use the format you request unless we cannot practicably do so. We may charge a reasonable fee for copies of PHI (based on our costs), for postage, and for a custom summary or explanation of PHI. You will receive notification of any fee(s) to be charged before we release your PHI, and you will have the opportunity to modify your request in order to avoid and/or reduce the fee. In certain situations we may deny your request for access to your PHI. If we do, we will tell you our reasons in writing, and explain your right to have the denial reviewed.

Right to Amend Your PHI: You have the right to request that we amend your PHI if you believe there is a mistake in your PHI, or that important information is missing. Approved amendments made to your PHI will also be sent to those who need to know, including (where appropriate) AmeriHealth’s vendors (known as "Business Associates"). We may also deny your
request if, for instance, we did not create the information you want amended. If we deny your request to amend your PHI, we will tell you our reasons in writing, and explain your right to file a written statement of disagreement.

**Right to an Accounting of Certain Disclosures:** You may request, in writing, that we tell you when we or our Business Associates have disclosed your PHI (an “Accounting”). Any accounting of disclosures will not include those we made:

- for payment, or health care operations;
- to you or individuals involved in your care;
- with your authorization;
- for national security purposes;
- to correctional institution personnel; or

The first accounting in any 12-month period is without charge. We may charge you a reasonable fee (based on our cost) for each subsequent accounting request within a 12-month period. If a subsequent request is received, we will notify you of any fee to be charged, and we will give you an opportunity to withdraw or modify your request in order to avoid or reduce the fee.

**Right to Request Restrictions:** You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to your request. However, if we do agree, we will be bound by our agreement except when required by law, in emergencies, or when information is necessary to treat you. An approved restriction continues until you revoke it in writing, or until we tell you that we are terminating our agreement to a restriction.

**Right to Request Confidential Communications:** You have the right to request that we use alternate means or an alternative location to communicate with you in confidence about your PHI. For instance, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. Your written request must clearly state that the disclosure of all or part of your PHI at your current address or method of contact we have on record could be an endangerment to you. We will require that you provide a reasonable alternate address or other method of contact for the confidential communications. In assessing reasonableness, we will consider our ability to continue to receive payment and conduct health care operations effectively, and the subscriber’s right to payment information. We may exclude certain communications that are commonly provided to all members from confidential communications. Examples of such communications include benefit booklets and newsletters.

**Right to a Paper Copy of This Notice:** You have the right to receive a paper copy of our Notice of Privacy Practices. You can request a copy at any time, even if you have agreed to receive this Notice electronically. To request a paper copy of this Notice, please contact Member Services at the telephone number on the back of your Member Identification Card.

**Right to Notification of a Breach of Your PHI:** You have the right to and will be notified following a breach of your unsecured PHI or if a security breach occurs involving your PHI.

**Your Right to File a Privacy Complaint**
If you believe your privacy rights have been violated, or if you are dissatisfied with AmeriHealth’s privacy practices or procedures, you may file a complaint with the AmeriHealth
Privacy Office and with the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

To file a privacy complaint with us, you may contact Member Services at the telephone number on the back of your ID card, or you may contact the Privacy Office as follows:

AmeriHealth
Privacy Office
P.O. Box 41762
Philadelphia, PA 19101 – 1762

Fax: 215-241-4023 or 1-888-678-7006 (toll-free)
E-mail: Privacy@amerihealth.com
Phone: 215-241-4735 or 1-888-678-7005 (toll-free)

Hearing-impaired TTY users may call 711 to receive assistance free of charge.

Para obtener asistencia en Español, por favor comuníquese con el Servicio de Atención al Cliente al número que figura en su tarjeta de identificación.

Upang makakuha ng tulong sa Tagalog, tumawag sa numero ng telepono ng serbisyong pangkostumer na nakalista sa iyong card ng pagkikilanlan.

要取得中文協助，請拨打列示在您身份證上的客戶服務電話。

Táá Diné k’ehjí shíka ’adoowoł nínízingo, ninaaltsoos bee ééhózinígíí béésh bee hane’é bikáá’ bee bik’e’ashchinígíí bich’i’ hodíílnih.