



*Please read the following information so you will know from whom or what group of providers health care may be obtained.*

## UMDNJ STUDENT & DEPENDENT DENTAL PLAN

### A COMPREHENSIVE DENTAL PLAN YOU CAN AFFORD

In an age of rising health care costs, Flagship Dental Plans, a subsidiary of Delta Dental Plan of New Jersey, Inc., offers an alternative way to provide for you and your family's dental care needs -- economically and conveniently through the DeltaCare program. Flagship was founded on the principle of delivering quality dental care and preventing dental problems before they start.

Flagship has contracted with a network of private dental offices, including the UMDNJ dental facilities conveniently located on or near the campuses. A panel listing of these offices is enclosed. As an enrollee in the DeltaCare program, you select one office from any of these dental offices for you and your family's needs. This network of dental offices is composed of established dental practices - not clinics. It has been found that most people feel more secure if the same dental office is providing for their family's treatment.

#### ■ ADVANTAGES

##### ***No Claim Forms***

The dental location you choose provides all primary dental services. There are no claim forms to complete.

##### ***No Deductibles***

In the DeltaCare program there are no required deductibles to pay so your benefits begin immediately.

##### ***No Dollar Limit of Dental Benefits***

No annual maximum.

##### ***No Pre-Existing Conditions Restricted***

These conditions are not excluded in a DeltaCare program. Exception: Work in progress.

##### ***Prepaid Plan Saves on Dental Costs***

Your out-of-pocket savings are substantial. You know the exact cost prior to treatment, and this aids in better fiscal planning for you and your family.

##### ***Quality Review of Dental Providers***

On-site audit of participating dental locations to insure that established standards of quality are maintained.

##### ***Specialty Services***

The DeltaCare program offers services in dental specialty areas. These include periodontics (treatment of diseased gums and bone), endodontics (root canal therapy), and oral surgery procedures.

#### ■ EMERGENCY SERVICES

You are also covered for out-of-area dental emergencies. This program will pay dental expenses incurred up to a maximum of \$50.00. "Out-Of-Area" means 35 miles or more from your Flagship participating dentist's office.

#### ■ HOW IT WORKS

1. When you enroll in DeltaCare, select a panel dental office from the list attached to this brochure. This location is now the center for all of your dental needs. 2. We ask you to select 3 panel dentists from 3 different offices. Your first choice takes priority. If for some reason that dentist is not available, we will automatically choose your second and/or third choice dentist and you will be notified of this change. 3. After you have enrolled, you will receive an Evidence of Coverage booklets that fully describes the benefits of your dental plan. To receive all necessary dental care covered by the plan, simply call your selected panel dentist to make an appointment. 4. Remember to always contact your selected panel dentist. **Dental services which are not performed by your panel dentist or prior authorized by Flagship will not be covered by the DeltaCare program.**

#### ■ WHO CAN JOIN

Eligible UMDNJ students can enroll in DeltaCare. You can also enroll your eligible dependents, which include your lawful spouse and unmarried children, including step-children, legally adopted and foster children to age 19.

#### ■ SUMMARY OF BENEFITS

The DeltaCare program provides all reasonable and customary dental care (subject to the master contract provisions, limitations and exclusions) if care is rendered by the patient's primary care dentist. There is no cost for covered services except for copayments on certain procedures. (See Description of Benefits and Copayments.)

# LIMITATIONS AND EXCLUSIONS OF BENEFITS

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## ■ LIMITATIONS

The benefits, as previously outlined, are subject to the following limitations:

1. Cleanings limited to two (2) treatments in any twelve (12) consecutive months.
2. Full upper and/or lower dentures are not to be installed or replaced more than once in any five (5) year period. Replacement of an existing denture or bridge will only be provided by Flagship if it is unsatisfactory and cannot be made satisfactory.
3. Partial dentures are not to be replaced within any five (5) year period unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
4. Fixed bridges will be authorized ONLY when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment. The patient would then be responsible for the difference between the cost of a partial and a fixed bridge.
5. Denture relines limited to one (1) during any twelve (12) consecutive months.
6. Periodontal treatment limited to five (5) during any twelve (12) consecutive months.
7. Bite-wing x-rays limited to not more than one (1) series of four (4) films in any six (6) month period.
8. Full mouth x-rays limited to one (1) set every thirty-six (36) consecutive months.

## ■ EXCLUSIONS

The following services are not covered by the Flagship prepaid dental plan:

1. Services rendered for injuries or conditions which are compensable under Workmen's Compensation or Employer's Liability Laws; services provided by any Federal, State or Provincial government agency; or services which are provided without cost to the covered person by any municipality, county, or political subdivision or community agency.
2. Services rendered or items furnished for any conditions, disease, ailment or injury occurring while the covered person is on active duty during military service, or for services or items provided under the laws of the United States of America or any state of the United States or any foreign country or of any political subdivision of any of the foregoing.
3. Surgical procedures to correct congenital malformations or developmental malformations, and procedures, alliances or restorations solely for cosmetic purposes or to increase vertical dimension, restore occlusion or restore tooth structure by lost attrition.
4. Analgesics (such as nitrous oxide) or other euphoric or prescription drugs.
5. Procedures primarily for the purpose of plaque control (except prophylaxis), oral hygiene or dietary instructions.
6. All other services not specifically included in the Group Contract between Flagship and the employer.
7. Hospital charges of any kind.
8. Major surgery of fractures and dislocations. Loss or theft of dentures or bridgework.
9. Lost, stolen or broken orthodontic appliances.
10. Dental expenses incurred in connection with any dental procedure started after termination of eligibility for coverage under the Flagship prepaid dental plan.
11. Dental expenses incurred in connection with any dental procedure started prior to a covered person's eligibility under the Flagship prepaid dental plan. (Example: teeth prepped for crowns, root canals in progress).
12. Malignancies.
13. Any dental procedure unable to be performed in the dental office because of the general health and physical limits of the patient.
14. Full mouth rehabilitation.
15. Services or treatment, which in the opinion of the plan dentist, are not necessary for the patient's dental health.

## ■ ORTHODONTIC LIMITATIONS AND EXCLUSIONS

Flagship's capitation program provides coverage for orthodontic treatment plans provided by an orthodontist that has contracted to treat DeltaCare patients.

1. Orthodontic treatment must be provided by a member of the Flagship orthodontic panel.
  2. Plan benefits cover twenty-four (24) months of usual and customary orthodontic treatment.
  3. The following are not benefits included: lost or broken appliances, retreatment of orthodontic cases, treatment in progress at inception of eligibility, changes in treatment necessitated by accident of any kind, surgical procedures (including extraction of teeth solely for the purpose of orthodontia) incidental to orthodontic treatment, myofunctional therapy, surgical procedures related to cleft palate, micrognathia or macrognathia, treatment related to temporomandibular joint disturbances and/or hormonal imbalance, dispensing of drugs, general anesthetics including intravenous and inhalation sedation, dental services of any nature performed in a hospital, any dental procedure considered within the field of general dentistry such as fillings or extractions, malocclusions which are so severe or mutilated so as not to be amenable to ideal orthodontic therapy, treatment that extends beyond twenty-four (24) months from the beginning of active treatment will be subject to an office visit charge.
  4. If a Covered Person does not require treatment or refuses to complete treatment, he/she will still be required to pay the orthodontist start-up costs not to exceed \$350.00 for the initial examination, diagnosis, consultation, study-model impressions, and the retention phase of treatment.
  5. The European method of orthodontia - activator appliances used in conjunction with eventual banding - is to be considered as full treatment.
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# PLAN HIGHLIGHTS AND DESCRIPTION OF BENEFITS



## Flagship Dental Plans

*Flagship Dental Plans is a subsidiary of Delta Dental Plan of New Jersey, Inc., the leading provider of group dental benefits in New Jersey.*

### PLAN G DESIGN

### CHARGE

Preventive & Diagnostic	No Charge
Remaining Basic Benefits	See Attached
Crowns	See Attached
Prosthodontics	See Attached
Orthodontics	\$2,200 Patient Payment
<b>Annual Maximum</b>	Unlimited
<b>Deductible</b>	None

***YOU MUST SELECT AND UTILIZE A DELTA CARE  
PRIMARY DENTIST TO RECEIVE BENEFITS.***

PREMIUM FOR THIS PROGRAM <i>March 1, 2004 through July 31, 2004</i>	
<i>STUDENT</i>	\$ 126.26*
<i>STUDENT +1</i>	\$ 247.13*
<i>STUDENT + TWO OR MORE</i>	\$ 387.04*

\* Includes administrative fee.

## DESCRIPTION OF BENEFITS & COPAYMENTS DELTA CARE PLAN G

**LISTED BELOW ARE SOME OF THE MOST COMMONLY PERFORMED PROCEDURES.**

**Average Charge** indicates what the provider traditionally charges for the procedure. You are responsible for the **Co-Payment**.

PROCEDURE	CO-PAYMENT	AVERAGE CHARGE
Initial Oral Exam	\$ 0.00	\$ 35.00
Periodic Oral Exam	\$ 0.00	\$ 28.00
X-rays, Complete Series	\$ 0.00	\$ 72.00
Bitewing X-rays, 2 films	\$ 0.00	\$ 20.00
Bitewing X-rays, 4 films	\$ 0.00	\$ 32.00
Cleaning, adult	\$ 0.00	\$ 58.00
Cleaning, child	\$ 0.00	\$ 40.00
Silver filling, 1 Tooth Surface	\$ 0.00	\$ 75.00
Silver Filling, 2 Tooth Surfaces	\$ 0.00	\$ 100.00
Silver Filling, 3 Tooth Surfaces	\$ 0.00	\$ 115.00
Composite Resin Filling, 1 Tooth Surface	\$ 0.00	\$ 82.00
Composite Resin Filling, 2 Tooth Surfaces	\$ 0.00	\$ 105.00
Porcelain Crown with Metal	\$ 240.00	\$ 710.00
Root Canal Therapy, Anterior Tooth	\$ 125.00	\$ 425.00
Root Canal Therapy, Bicuspid Tooth	\$ 150.00	\$ 500.00
Root Canal Therapy, Molar Tooth	\$ 200.00	\$ 625.00
Gingival Curettage, per Quadrant	\$ 30.00	\$ 120.00
Osseous Surgery, per Quadrant	\$ 210.00	\$ 640.00
Periodontal Root Planing and Scaling, per Quadrant	\$ 35.00	\$ 140.00
Upper Partial Denture	\$ 270.00	\$ 800.00
Bridge Abutment (crown), Porcelain with Metal	\$ 240.00	\$ 710.00
Simple Extraction, Single Tooth	\$ 0.00	\$ 88.00
Extraction of Impacted Tooth Completely Covered by Bone	\$ 0.00	\$ 375.00



**November 2002**

ADMINISTERED BY:

FLAGSHIP DENTAL PLANS  
 1639 ROUTE 10  
 PARSIPPANY, NEW JERSEY 07054  
 IN NEW JERSEY: 1-800-722-3524    OUT OF AREA: 1-800-848-3524

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If you have any questions or need additional  
information call or write:



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FLAGSHIP DENTAL PLANS  
1639 ROUTE 10  
PARSIPPANY, NEW JERSEY 07054***

***IN NEW JERSEY: 1-800-722-3524  
OUT OF AREA: 1-800-848-3524***

**NOTE:**

**THIS IS ONLY A BRIEF SUMMARY OF THE PLAN.** The dental health plan contract must be consulted to determine the exact terms and conditions of coverage. An Evidence of Coverage will be sent to you upon enrollment.