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**Life – Health – Disability Insurance  
Employee Benefit Plans**

Thank you for your interest in The Solinsky Financial Group Dental Plan. SFG acts as the Plan Administrator, but the Managed Care Plan is provided by Employers Dental Services (EDS), one of the oldest and largest Managed Care Plans in Arizona. EDS offers quality, affordable, dental services by contracting with participating Primary Care Dentists throughout Arizona. For your convenience, many of these have extended office hours.

Coverage begins the first day of the month after the initial payment and enrollment information is received by SFG. You may stay on the plan for as long as you wish, as long as you continue to pay your premiums to [AVX Enterprises](#). However, **you must remain on the plan for a minimum of one year.** Also, **coverage needs to be continuous.** You cannot get on and off the plan at will. If you do lapse, then wish to come back on, recontracting occurs and there is a fee for the time between the cancellation and recontracting dates.

There are no claim forms, no deductibles, and no yearly maximums. All pre-existing conditions are covered except for those procedures that are in progress. EDS offers an orthodontic (braces) benefit for both children and adults. Refer to the schedule of benefits for a complete list of covered procedures and member costs. When the services of a Specialist are required, the member may receive those services from a participating EDS authorized Specialist, where one is available. Where a participating EDS authorized Specialist is available, the member pays a reduced fee from the authorized Specialist's normal office charges.

The family rate is for the entire family, no matter how many children. But, children are only covered until the limiting age. You choose, single or family coverage. Follow these directions to enroll in The Solinsky Financial Group Dental Plan through EDS:

1. Complete the enrollment card. Select a Dental Facility from the list of participating Dentists (use the code number).
2. Make out your check to [AVX Enterprises](#) for the premium amount.
3. Send the enrollment card (both copies) and the **check** for the premium to:

The Solinsky Financial Group, Inc.  
11240 E. Calle Vaqueros  
Tucson, AZ 85749

After the initial premium payment that accompanies the enrollment form, you will be billed through the mail for this valuable coverage.

INDIVIDUALS:	\$ 187.00 Annually	MEMBER & DEPENDENTS:	\$ 412.00 Annually
	\$ 96.00 Semi-annual		\$ 211.00 Semi-annual

**11240 E. Calle Vaqueros \* Tucson, Arizona 85749**  
**Toll Free (877) 885-6623**  
**\* (520) 885-6623 \* (520) 203-0216 -fax \* email [Phil@Solinsky-inc.com](mailto:Phil@Solinsky-inc.com)**



# Employers Dental Services

Enrollment and Coverage Booklet  
EDS 700R



Employers  
Dental  
Services

*A Company of the  
Principal Financial Group*

WE UNDERSTAND WHAT YOU'RE WORKING FOR<sup>SM</sup>

**Principal<sup>®</sup>**  
*Financial  
Group*

# Did You Know?

- About 80% of the population believes that a smile is very important to a person's appearance. (May 1998)\*
- At least 60% of adults in the US have moderate to severe gum disease. (July 1999)\*
- Periodontal (gum) disease is America's number-one oral health issue. (March 1999)\*
- Oral diseases and conditions are associated with other health problems\*\*
- 18% of 2 to 4 year old children have experienced tooth decay and 16% have untreated decay.\*\*
- As a result of dental disease:
  - Employed adults lose more than 164 million hours of work each year
  - More than 51 million school hours are lost each year\*\*

\* ADA News Releases

\*\* Office of the Surgeon General  
Oral Health 2000, Facts and Figures  
Oral Health in America, A Report of the Surgeon General (2000)

## Contents

	Page
General Information .....	3
Schedule of Benefits .....	4
Orthodontics .....	6
TMJ/TMD — Temporomandibular Joint Dysfunction ..	7
Emergency Care .....	7
Prescription Discount Program .....	8
Eligible Dependents .....	8
Conversion Plan .....	8
Member Rights and Responsibilities .....	9
Exclusions & Limitations .....	10
Grievance & Appeals Process .....	11

## Questions?

### *Customer Service* Can Help

- Select a dentist
- Change your current dentist  
*(changes received by the 24th of the month will be effective the first of the following month)*
- Process a new ID card
- Resolve and report a concern
- Explain the formal grievance process
- Explain benefits and your costs
- Process a change of address
- Facilitate care for a dental emergency

#### **If you need assistance, please call:**

Customer Service

Phoenix: (602) 248-8912

Tucson: (520) 696-4343

Statewide: 1-800-722-9772

*Spanish speaking representatives available*

P.O. Box 36600

Tucson, AZ 85740-6600

**[www.mydentalplan.net](http://www.mydentalplan.net)**

# Employers Dental Services

A Company of the Principal Financial Group®

*Employers Dental Services is a prepaid dental care organization that has been committed to delivering dental care at an affordable cost since 1974.*

## Advantages

- No Deductibles
- No Claim Forms
- No Yearly Maximums
- No Waiting Period for Basic, Preventive or Major Services
- Coverage for Pre-existing Conditions, except Procedures in Progress
- Orthodontic Benefits for Children & Adults
- Prescription Discount Program
- Customer Service Department based in Arizona
- Large Network of Participating Dentists
- Emergency Benefit 24 Hours a Day
- EDS Dentists Participate in our Quality Management and Peer Review Programs
- Value and Affordability with Focus on Preventive Procedures

## Enrollment

- Please read this Enrollment and Coverage Booklet carefully.
- You are eligible after you have met your employer's waiting period or during your employer's annual open enrollment.
- Select a dentist from the EDS DIRECTORY OF PARTICIPATING DENTISTS AND SPECIALISTS for you and your family. You and your enrolled dependents will be seen by the dental office you choose.
- Complete **all** sections of your enrollment form.
- Return your completed enrollment form to your Benefits Administrator.
- You will receive an ID card after your effective date. Your ID card is **not** required for dental appointments.
- Your Benefits Administrator will be able to assist you with your enrollment.

## Appointments

- Schedule your appointment with your chosen dental office after your effective date.
- Your first appointment will be to meet the dentist and receive an evaluation of your oral health.
- If you are unable to keep your scheduled appointment, please notify the dental office at least 24 hours in advance or a missed appointment fee will be charged.
- Office policies and practices vary by dental office. Not all dentists perform all procedures.
- Your dentist will answer questions about your treatment plan.

## Member Costs

- An office visit fee will be charged at each appointment.
- All fees will be paid to the dental office at the time services are rendered.
- Your member costs, listed on the following pages of this booklet, are for procedures performed by your chosen EDS general dentist.
- The column listed as average costs represents what you could expect to pay without any dental coverage.



# Schedule of Benefits EDS 700R

## Specialists

### Endodontists, Oral Surgeons, Pediatric Dentists, Periodontists, Prosthodontists and TMD Dentists

EDS Specialists offer up to 25% off their normal fees for services specifically described in this schedule of benefits. All fees will be paid to the specialist at the time of treatment. **A referral is not required.**

## General Dentists

Member costs listed below are for services provided by your chosen EDS General Dentist.

ADA CODE	CDT - PROCEDURE DESCRIPTION	AVERAGE COST	MEMBER COST
<b>DIAGNOSTIC — Procedures that aid the dentist in evaluating existing conditions and determining what dental care is required.</b>			
09431	OFFICE VISIT - PER PATIENT/PER VISIT		5.00
D0120	PERIODIC ORAL EVALUATION	34.00	NO CHARGE
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	56.00	20.00
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	55.00	NO CHARGE
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY PERIODONTIST'S REPORT		55.00
D0170	RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT)	72.00	15.00
D0180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT	56.00	NO CHARGE
D0210	X-RAYS - COMPLETE SERIES (INCLUDING BITEWINGS)	90.00	NO CHARGE
D0220	X-RAYS - FIRST FILM	19.00	NO CHARGE
D0230	X-RAYS - EACH ADDITIONAL FILM	16.00	NO CHARGE
D0240	X-RAYS - OCCLUSAL	20.00	NO CHARGE
D0270	X-RAYS - BITEWING - SINGLE FILM	18.00	NO CHARGE
D0272	X-RAYS - BITEWINGS - TWO FILMS	29.00	NO CHARGE
D0274	X-RAYS - BITEWINGS - FOUR FILMS	41.00	NO CHARGE
D0330	X-RAYS - PANORAMIC FILM	75.00	NO CHARGE
D0460	PULP VITALITY TESTS	28.00	NO CHARGE
D0470	DIAGNOSTIC CASTS	79.00	10.00

<b>PREVENTIVE — Procedures that prevent the occurrence of oral diseases.</b>			
D1110	CLEANING ADULT (PROPHYLAXIS)	65.00	7.00
D1120	CLEANING CHILD (PROPHYLAXIS)	50.00	5.00
D1201	TOPICAL APPLICATION OF FLUORIDE & CLEANING (INCLUDING PROPHYLAXIS) - CHILD	70.00	7.00
D1203	TOPICAL APPLICATION OF FLUORIDE (PROPHYLAXIS NOT INCLUDED) - CHILD	23.00	NO CHARGE
D1310	NUTRITIONAL COUNSELING FOR CONTROL OF DENTAL DISEASE	30.00	NO CHARGE
D1330	ORAL HYGIENE INSTRUCTIONS	35.00	NO CHARGE
D1351	SEALANT - PER TOOTH	36.00	12.00
D1510	SPACE MAINTAINER - FIXED - UNILATERAL	221.00	25.00+LAB
D1515	SPACE MAINTAINER - FIXED - BILATERAL	334.00	25.00+LAB
D1520	SPACE MAINTAINER - REMOVABLE - UNILATERAL	225.00	25.00+LAB
D1525	SPACE MAINTAINER - REMOVABLE - BILATERAL	389.00	25.00+LAB
D1550	RECEMENTATION OF SPACE MAINTAINER	50.00	20.00

<b>RESTORATIVE — Procedures for restoring lost tooth structure.</b>			
D2140	AMALGAM FILLING - ONE SURFACE, PRIMARY OR PERMANENT	103.00	13.00
D2150	AMALGAM FILLING - TWO SURFACES, PRIMARY OR PERMANENT	125.00	17.00
D2160	AMALGAM FILLING - THREE SURFACES, PRIMARY OR PERMANENT	150.00	21.00
D2161	AMALGAM FILLING - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	160.00	30.00
D2330	RESIN FILLING - ONE SURFACE, ANTERIOR	110.00	30.00
D2331	RESIN FILLING - TWO SURFACES, ANTERIOR	138.00	40.00

ADA CODE	CDT - PROCEDURE DESCRIPTION	AVERAGE COST	MEMBER COST
D2332	RESIN FILLING - THREE SURFACES, ANTERIOR	162.00	50.00
D2335	RESIN FILLING - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	190.00	60.00
D2390	RESIN-BASED COMPOSITE CROWN-ANTERIOR	180.00	70.00
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR	120.00	35.00
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR	155.00	42.00
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR	190.00	52.00
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR	216.00	55.00
D2510	INLAY-METALLIC - ONE SURFACE	450.00	135.00+LAB
D2520	INLAY-METALLIC - TWO SURFACES	650.00	150.00+LAB
D2530	INLAY-METALLIC - THREE SURFACES	795.00	170.00+LAB
D2721	CROWN-RESIN WITH PREDOMINATELY BASE METAL	600.00	280.00+LAB
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	803.00	280.00+LAB
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	750.00	280.00+LAB
D2751	CROWN-PORCELAIN FUSED TO PREDOMINATELY BASE METAL	690.00	280.00+LAB
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	720.00	280.00+LAB
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL	720.00	280.00+LAB
D2781	CROWN - 3/4 CAST PREDOMINATELY BASE METAL	665.00	280.00+LAB
D2782	CROWN - 3/4 CAST PREDOMINATELY NOBLE METAL	690.00	280.00+LAB
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	700.00	280.00+LAB
D2790	CROWN - FULL CAST HIGH NOBLE METAL	750.00	280.00+LAB
D2791	CROWN - FULL CAST PREDOMINATELY BASE METAL	710.00	280.00+LAB
D2792	CROWN - FULL CAST NOBLE METAL	715.00	280.00+LAB
D2799	PROVISIONAL - CROWN - USED AS AN INTERIM RESTORATION OF AT LEAST 6 MONTHS	200.00	38.00
D2910	RECEMENT INLAY	70.00	20.00
D2920	RECEMENT CROWN	73.00	20.00
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH	175.00	60.00
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH	200.00	60.00
D2940	SEDATIVE FILLING	72.00	25.00
D2950	CORE BUILDUP INCLUDING PINS	178.00	40.00
D2951	PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION	50.00	40.00
D2952	CAST POST AND CORE IN ADDITION TO CROWN	288.00	70.00+LAB
D2953	EACH ADDITIONAL CAST POST - SAME TOOTH	150.00	45.00+LAB
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	220.00	70.00
D2970	TEMPORARY CROWN (FRACTURED TOOTH)	160.00	40.00

<b>ENDODONTICS (Root Canal Therapy) — Procedures for treating diseases of the dental pulp (nerve).</b>			
D3110	PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)	57.00	5.00
D3120	PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION)	45.00	5.00
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)	113.00	30.00
D3221	PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH	150.00	55.00
D3230	PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR PRIMARY TOOTH	170.00	75.00
D3240	PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR PRIMARY TOOTH	221.00	85.00
D3310	ROOT CANAL - ANTERIOR	530.00	185.00
D3320	ROOT CANAL - BICUSPID	650.00	220.00
D3330	ROOT CANAL - MOLAR	855.00	305.00
D3346	RETREATMENT OF PREVIOUS ROOT CANAL - ANTERIOR	667.00	320.00
D3347	RETREATMENT OF PREVIOUS ROOT CANAL - BICUSPID	750.00	350.00
D3348	RETREATMENT OF PREVIOUS ROOT CANAL - MOLAR	950.00	450.00
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VISIT	283.00	90.00
D3352	APEXIFICATION/RECALCIFICATION - INTERIM MEDICATION REPLACEMENT	142.00	90.00
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	575.00	90.00
D3410	APICOECTOMY/PERIRADICULAR SURGERY - ANTERIOR	550.00	170.00
D3421	APICOECTOMY/PERIRADICULAR SURGERY - BICUSPID (FIRST ROOT)	675.00	170.00
D3425	APICOECTOMY/PERIRADICULAR SURGERY - MOLAR (FIRST ROOT)	795.00	170.00
D3426	APICOECTOMY/PERIRADICULAR SURGERY - (EACH ADDITIONAL ROOT)	212.00	125.00
D3430	RETROGRADE FILLING - PER ROOT	200.00	90.00
D3450	ROOT AMPUTATION - PER ROOT	390.00	90.00
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL)	250.00	90.00

ADA CODE	CDT - PROCEDURE DESCRIPTION	AVERAGE COST	MEMBER COST	ADA CODE	CDT - PROCEDURE DESCRIPTION	AVERAGE COST	MEMBER COST
<b>PERIODONTICS — Procedures for treating diseases of the gingival tissues (gums) and periodontal membrane.</b>				D6242	PONTIC - PORCELAIN FUSED TO NOBLE METAL	715.00	280.00+LAB
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE TEETH OR BOUNDED TEETH SPACES PER QUADRANT	410.00	225.00	D6245	PONTIC - PORCELAIN/CERAMIC	770.00	280.00+LAB
D4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE TEETH, PER QUADRANT	147.00	150.00	D6251	PONTIC - RESIN FUSED TO PREDOMINANTLY BASE METAL	600.00	280.00+LAB
D4240	GINGIVAL FLAP PROCEDURES, INCLUDING ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	625.00	250.00	D6545	RETAINER - CAST METAL FOR RESIN BONDED FIXED PROSTHESIS	435.00	175.00+LAB
D4241	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT	490.00	200.00	D6721	CROWN - RESIN FUSED TO PREDOMINANTLY BASE METAL	600.00	280.00+LAB
D4249	CLINICAL CROWN LENGTHENING - HARD TISSUE	650.00	250.00	D6740	CROWN - PORCELAIN/CERAMIC	850.00	280.00+LAB
D4260	OSSEOUS SURGERY (INCLUDING FLAP ENTRY & CLOSURE) - FOUR OR MORE TEETH PER QUADRANT	870.00	365.00	D6750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	750.00	280.00+LAB
D4261	OSSEOUS SURGERY - ONE TO THREE TEETH, PER QUADRANT	880.00	300.00	D6751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	730.00	280.00+LAB
D4320	PROVISIONAL SPLINTING - INTRACORONAL	165.00	75.00	D6752	CROWN - PORCELAIN FUSED TO NOBLE METAL	723.00	280.00+LAB
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	310.00	80.00	D6780	CROWN - 3/4 CAST HIGH NOBLE METAL	720.00	280.00+LAB
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH, PER QUADRANT	200.00	90.00	D6781	CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	665.00	280.00+LAB
D4342	PERIODONTAL SCALING & ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT	165.00	75.00	D6782	CROWN - 3/4 CAST NOBLE METAL	690.00	280.00+LAB
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS	140.00	80.00	D6783	CROWN - 3/4 PORCELAIN/CERAMIC	700.00	280.00+LAB
D4381	LOCALIZED DELIVERY OF CHEMOTHERAPEUTIC AGENTS (PER SITE)		25.00	D6790	CROWN - FULL CAST HIGH NOBLE METAL	745.00	280.00+LAB
D4910	PERIODONTAL MAINTENANCE	97.00	60.00	D6791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	625.00	280.00+LAB
<b>PROSTHODONTICS — Procedures for providing artificial replacements for missing natural teeth.</b>				D6792	CROWN - FULL CAST NOBLE METAL	710.00	280.00+LAB
D5110	COMPLETE DENTURE - UPPER	1,000.00	325.00+LAB	D6930	RECEMENT FIXED PARTIAL DENTURE	103.00	30.00
D5120	COMPLETE DENTURE - LOWER	950.00	325.00+LAB	D6972	PREFABRICATED POST AND CORE IN ADDITION TO FIXED PARTIAL DENTURE RETAINER	225.00	60.00
D5130	IMMEDIATE DENTURE - UPPER	1,100.00	325.00+LAB	<b>ORAL SURGERY — Procedures for treating nonrestorable teeth and diseases or injury in the oral cavity.</b>			
D5140	IMMEDIATE DENTURE - LOWER	1,000.00	325.00+LAB	D7111	CORONAL REMNANTS - DECIDUOUS TOOTH	100.00	35.00
D5211	UPPER PARTIAL DENTURE - RESIN BASE	775.00	375.00+LAB	D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	128.00	55.00
D5212	LOWER PARTIAL DENTURE - RESIN BASE	875.00	375.00+LAB	D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH	187.00	60.00
D5213	UPPER PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	1,050.00	400.00+LAB	D7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	187.00	85.00
D5214	LOWER PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	1,050.00	400.00+LAB	D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	225.00	100.00
D5281	REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH)	440.00	160.00+LAB	D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	268.00	120.00
D5410	ADJUST COMPLETE DENTURE - UPPER	64.00	25.00	D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	195.00	70.00
D5411	ADJUST COMPLETE DENTURE - LOWER	53.00	25.00	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH	250.00	150.00
D5421	ADJUST PARTIAL DENTURE - UPPER	53.00	25.00	D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - PER QUADRANT	175.00	110.00
D5422	ADJUST PARTIAL DENTURE - LOWER	53.00	25.00	D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - PER QUADRANT	200.00	110.00
D5510	REPAIR BROKEN COMPLETE DENTURE BASE	134.00	20.00+LAB	D7510	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE	150.00	80.00
D5520	REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE (EACH TOOTH)	110.00	20.00+LAB	D7960	FRENECTOMY (FRENECTOMY OR FRENOTOMY) - SEPARATE PROCEDURE	316.00	90.00
D5610	REPAIR RESIN DENTURE BASE	119.00	20.00+LAB	D7971	EXCISION OF PERICORONAL GINGIVA	140.00	90.00
D5620	REPAIR CAST FRAMEWORK	155.00	20.00+LAB	D7997	APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE), INCLUDES REMOVAL OF ARCHBAR	48.00	25.00
D5630	REPAIR OR REPLACE BROKEN CLASP	179.00	20.00+LAB	<b>OTHER SERVICES</b>			
D5640	REPLACE BROKEN TEETH-PER TOOTH	112.00	20.00+LAB	D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN - MINOR PROCEDURES	84.00	5.00
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	150.00	20.00+LAB	D9230	ANALGESIA (NITROUS OXIDE)	44.00	25.00
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	130.00	20.00+LAB	D9430	OFFICE VISIT FOR OBSERVATION DURING REGULARLY SCHEDULED HOURS - NO OTHER SERVICES PERFORMED	50.00	NO CHARGE
D5710	REBASE COMPLETE UPPER DENTURE	350.00	20.00+LAB	D9431	OFFICE VISIT - PER PATIENT/PER VISIT	7.00	5.00
D5711	REBASE COMPLETE LOWER DENTURE	350.00	20.00+LAB	D9440	OFFICE VISIT - AFTER REGULARLY SCHEDULED HOURS	105.00	45.00
D5720	REBASE UPPER PARTIAL DENTURE	350.00	20.00+LAB	D9630	OTHER DRUGS AND/OR MEDICAMENTS	45.00	UCR
D5721	REBASE LOWER PARTIAL DENTURE	350.00	20.00+LAB	D9630	PERIDEX (PERIODONTAL HOME CARE)	12.00	12.00
D5730	RELINE COMPLETE UPPER DENTURE (CHAIRSIDE)	200.00	69.00	D9920	BEHAVIOR MANAGEMENT, BY REPORT	165.00	35.00
D5731	RELINE COMPLETE LOWER DENTURE (CHAIRSIDE)	180.00	69.00	D9940	OCCLUSAL GUARD, BY REPORT	416.00	90.00+LAB
D5740	RELINE UPPER PARTIAL DENTURE (CHAIRSIDE)	180.00	69.00	D9951	OCCLUSAL ADJUSTMENT LIMITED	75.00	45.00
D5741	RELINE LOWER PARTIAL DENTURE (CHAIRSIDE)	180.00	69.00	D9952	OCCLUSAL ADJUSTMENT COMPLETE	325.00	120.00
D5750	RELINE COMPLETE UPPER DENTURE (LABORATORY)	286.00	25.00+LAB	D9972	EXTERNAL BLEACHING - PER ARCH	150.00	145.00
D5751	RELINE COMPLETE LOWER DENTURE (LABORATORY)	275.00	25.00+LAB	D9973	EXTERNAL BLEACHING - PER TOOTH	125.00	60.00
D5760	RELINE UPPER PARTIAL DENTURE (LABORATORY)	360.00	25.00+LAB	D9974	INTERNAL BLEACHING - PER TOOTH	162.00	60.00
D5761	RELINE LOWER PARTIAL DENTURE (LABORATORY)	250.00	25.00+LAB	D9988	MISSED APPOINTMENT - FIRST	25.00	25.00
D5820	INTERIM PARTIAL DENTURE (UPPER)	350.00	150.00+LAB	D9988	MISSED APPOINTMENT - ADDITIONAL	35.00	25.00
D5821	INTERIM PARTIAL DENTURE (LOWER)	394.00	150.00+LAB		RECORDS TRANSFER - DUPLICATION FEE	20.00	UCR
D5850	TISSUE CONDITIONING, UPPER	120.00	20.00				
D5851	TISSUE CONDITIONING, LOWER	120.00	20.00				
D6210	PONTIC - CAST HIGH NOBLE METAL	745.00	280.00+LAB				
D6211	PONTIC - CAST PREDOMINANTLY BASE METAL	620.00	280.00+LAB				
D6212	PONTIC - CAST NOBLE METAL	665.00	280.00+LAB				
D6240	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL	747.00	280.00+LAB				
D6241	PONTIC - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	702.00	280.00+LAB				

**UCR:** Usual Customary and Reasonable or Normal Office Fees

**LAB:** Fees charged by the dental laboratory to fabricate certain dental products e.g. crowns, dentures or bridges. This fee varies depending on the dental laboratory and materials used.

# Orthodontics for Children and Adults

EDS Orthodontists offer 25% off their normal and customary fees.

There is:

- **No Waiting Period**
- **No Referral Required**
- **No Lifetime Benefit Maximum**

Treatment plan and payment terms are defined by the contract you sign with your chosen EDS Orthodontist.

EDS Coverage must be maintained for the duration of treatment in order to avoid normal and customary fees.

*Individuals receiving Orthodontic treatment under another program are not eligible to participate. This is considered treatment in progress and is therefore excluded.*



# Temporomandibular Joint Dysfunction - TMD

EDS provides coverage for the treatment of TMD as a part of your dental care benefit. Procedures and services for the treatment of TMD will be charged at up to 25% off the TMD dentist's office fees.

You may call an EDS TMD dentist at any time. Please consult the list of EDS TMD dentists in your area.

Referral from general dentist not required.

## Emergency Care Benefit

*The maximum allowable reimbursement is \$200 minus any member costs which are listed in this booklet.*

EDS provides coverage for dental emergencies. Please contact your EDS general dentist first. If you are unable to reach your EDS general dentist, you may seek care immediately from any licensed dentist.

EDS will provide coverage for the *temporary* relief of:

- Pain (palliative treatments to control pain),
- Bleeding, and
- Infection.

**Follow up or additional treatment must be done by your EDS general dentist.**

After emergency treatment, you may receive your reimbursement by submitting a copy of your paid itemized receipt to:

EDS  
P.O. Box 36600  
Tucson, AZ 85740-6600

The maximum allowable reimbursement for a dental emergency is \$200 **minus any member costs** which are listed in this booklet.





## Prescription Discount Program (not an insurance)

### What is the Prescription Discount Program?

It is a program that offers substantial discounts on prescription drugs purchased through affiliated pharmacies. As a member of Employers Dental Services you are eligible for a prescription drug benefit.

### How does the program work?

When you need to fill a prescription, go to one of the participating pharmacies and present your EDS I.D. card with the prescription. **YOU MUST PRESENT YOUR EDS CARD** to receive the following discount:

- **Brand Name** drugs are offered at the average wholesale price less 15%, plus a \$3.00 dispensing fee.
- **Generic Substitutes** are offered at the average wholesale price less 30%, plus a \$3.00 dispensing fee.

This program is not valid in combination with other discount plans, HMO prescription benefits or prescription cards. The program is available to EDS members and their families. All family members do not have to be enrolled in EDS to utilize the prescription discount program. This benefit is good on medical as well as dental prescriptions.

### Which stores participate in the Prescription Discount Program?

Currently, pharmacies located in Bashas', Fry's, and Safeway stores participate in APN.



## Eligible Dependents

Eligible dependents will include lawful spouse and unmarried children to age 19, or any unmarried children to age 25, who attend an accredited educational institution on a full time basis and are fully dependent on employee for support or as stated in the employer's master contract.

Participants may add dependents midyear if a marriage occurs. Participants may add dependents at date of employer group open enrollment.

Dependent newborns or adopted children or children placed for adoption will be eligible immediately upon birth or upon adoption or placement for adoption. All newly eligible dependents must be added within 31 days of change. Dependent children must be deleted when they are no longer eligible.

## EDS Conversion Plan

When your EDS coverage terminates, you have the option of converting to an EDS Conversion Plan. Please call our Customer Service Department at 1-800-722-9772 for information. Enrollment forms are accepted within 31 days of coverage termination.



# Member Rights and Responsibilities

## Member Rights

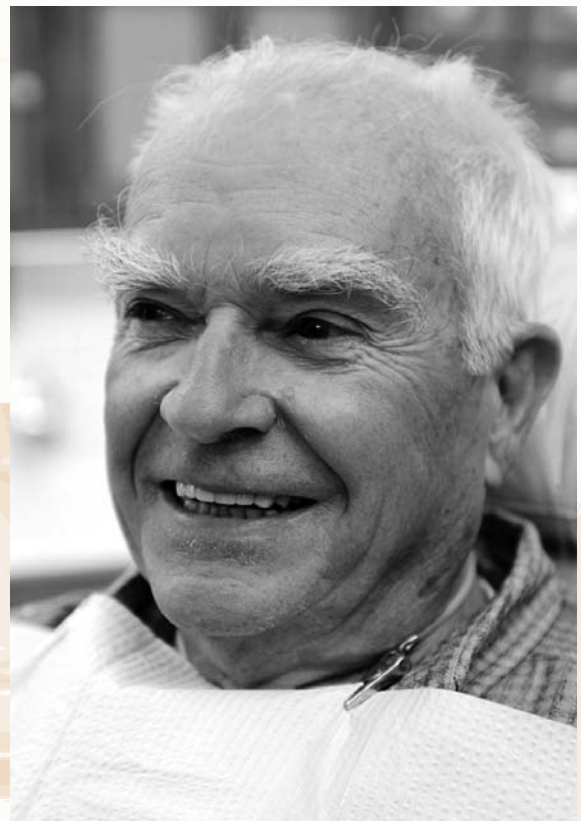
1. You have the right to have an initial appointment (non emergency) scheduled within 63 days of your request.
2. You have the right to have access to emergency dental health services 24 hours per day, 365 days per year.
3. You have the right to obtain appropriate care from your EDS participating dentist.
4. You have the right to considerate and respectful care from all participating primary care dentists and staff members in recognition of your dignity and need for privacy regardless of race, color, religion, sex, age, physical or mental handicap or national origin.
5. You have the right to be informed about your current dental health, treatment options, possible risks, likely outcomes, and to participate in decision-making with your participating dentist. This may include, but is not limited to obtaining a second opinion from another participating primary care dentist.
6. You have the right to voice recommendations for changes in policies and services to our company.
7. You have the right to voice grievances concerning our company, or the care delivered by our company's participating dentists.
8. You have the right to receive information regarding our company's appeals, complaint and grievance process and to receive a Formal Appeals and Grievance Brochure.
9. You have the right to receive information concerning changes in benefits or termination of any covered services or participating dentists that may affect you.
10. You have the right to receive information regarding your member cost and payment of charges for which you will be responsible before your dentist begins any procedure.
11. You have the right to expect that our company will provide you the necessary documents that explain your dental health care benefits, exclusions and limitations, our services, participating primary care dentists, how to obtain dental health care services and your member rights and responsibilities.
12. You have the right to expect that information concerning your dental records and the dentist/patient relationship is kept confidential unless you have given written permission to release such information, except when otherwise required or permitted by law.
13. You have the right to review your dental records, treatment plan, a progress report on treatment that has already been provided and to have the information explained to you except when restricted by law.
14. You have the right to change your participating primary care dentist by calling our Customer Service Department at 1-800-722-9772 by the 24th of any month. The change will be effective on the first day of the following month.
15. You have the right to have a recall appointment, at an interval specified by your dentist, to have your teeth cleaned and/or an oral examination.
16. You have the right to obtain care while temporarily out of the service area for infection, temporary relief of dental pain, and the control of bleeding due to dental problems, by going to the dentist of your choice.
17. You have the right, where available, to continue your dental health care coverage upon disenrollment through COBRA.
18. You have the right to have a Customer Service Representative assist you in getting an appointment and/or resolving problems by calling 1-800-722-9772.

## Member Responsibilities

1. You are responsible to recognize the effect of your lifestyle on your personal dental health.
2. You are responsible to call us at 1-800-722-9772 and report to our Customer Service Representative any situation where you perceive that your rights are violated.
3. You are responsible to provide, to the extent possible, accurate information needed by participating primary care dentists in order to provide care for your dental health including past illnesses, medical history and use of medicines.
4. You are responsible, if you have a written directive from another health-care provider, to provide a copy of this to your participating dentist.
5. You are responsible for selecting a participating primary care dentist with the goal of immediately establishing and maintaining an ongoing, well-communicated dentist/patient relationship.
6. You are responsible for following our company's guidelines for obtaining referrals and/or authorizations to participating specialists for care.
7. You are responsible for asking questions of your dental health professional when you do not understand information or instruction.
8. You are responsible to seek support from our Customer Service Department, by calling 1-800-722-9772, when you need assistance to access your dental health care benefits.
9. You are responsible for letting your dentist know if you feel that you will not be able to follow through with a recommended treatment plan or post operative instructions.
10. You are responsible to obtain and follow through with dental health care that is prescribed, or directed by your participating dentist that you agree to, and is authorized by our company.
11. You are responsible to show courtesy, consideration and respect to participating dentists, their staff and to our company's representatives.
12. You are responsible, not the dental office, to know what is covered and what is excluded from your dental plan.
13. You are responsible to understand and to pay, at the time of service, any required member costs for dental procedures as indicated in your Schedule of Benefits.
14. You are responsible to contact your participating primary care dentist for follow up dental care instructions following any emergency dental treatment.
15. You are responsible, as a parent or legal guardian, to stay in the dental office while your minor dependent child(ren) receives dental treatment.
16. You are responsible to provide 24 hours notice of cancellation on any appointment you are unable to keep. Failure to do so will result in a missed appointment fee being charged.
17. You are responsible to follow our guidelines as described above and in your enrollment and coverage brochure. If you are unable to do so, it will result in termination from the plan.

# Exclusions and Limitations

- Visits or services performed by a Dentist, Specialist or professional not contracted with Employers Dental Services except in connection with dental emergencies.
- Any dental services which, in the judgement of the Dentist, are not reasonable and necessary for the prevention, correction or improvement of a condition which is subject to treatment by the practice of dentistry.
- Programs or treatment, including prosthetics, which were in progress prior to the date any person became a member under this Plan.
- Any dental services related to any sickness or injury arising out of, or in the course of any occupation or unemployment for remuneration or profit. Also, any dental services for which the member is reimbursed, entitled to reimbursement, or is in any way indemnified for such expenses by, or through any public program, State, Federal or Local, or any program of medical benefits sponsored and paid for by the Federal Government, the State Government, any County or municipal government or any program of medical benefits sponsored and paid for by the Federal Government or any agency thereof.
- Any dental service not specifically described in the Schedule of Benefits.
- Any dental services, other than emergency dental services, which are related to accidents or accidental injury.
- Any costs or expenses incurred in the event the member desires to be or is involuntarily hospitalized for any dental procedures or services, except in connection with dental emergencies.
- Dispensing of drugs or any prescription drug charges incurred for treatment of oral disease except as may be specifically provided for in the Schedule of Benefits.
- Any dental services, other than emergency dental services, which are necessitated as a result of intentionally self inflicted condition.
- Oral surgery or extractions which are solely for orthodontic purposes or requiring the setting of fractures or dislocations, except as may be specifically provided for in the Schedule of Benefits.
- Treatment of malignancies, cysts, neoplasm or congenital defects.
- Conditions affecting the temporomandibular joint (TMJ) including dysfunction and/or malocclusion except as may be specifically provided for in the Schedule of Benefits.
- Any general anesthetic charges or services of an anesthetist or anesthesiologist.
- Gold foil restoration.
- Any dental services requiring, or pertaining to, cosmetic surgery for beautification, treatment of obesity and appliances or restoration necessary to increase vertical dimension or to restore an occlusion or to correct a congenital condition.
- Any new services or procedures performed after the last day of the month during which any person ceased to be eligible for participation under the Plan.
- If a member continually fails to follow a prescribed course of treatment, the treating EDS dentist may refuse to continue that course of treatment at any time.



# Formal Grievance & Appeals Process

## Levels of Review

EDS members may ask EDS to review its decisions involving their requests for services or requests to have claims paid. The Arizona State Legislatures have established six levels of review. Companies that perform utilization review activities after services are provided (EDS is in this category) are not required to provide the Expedited Appeals Level 1 (Expedited Dental Review), Level 2, (Expedited Appeal), Level 3 (Expedited External Independent Dental Review) or Standard Appeals Level 1 (Informal Reconsideration). EDS members have two levels of review available to them. They are Standard Appeals Level 2 (Formal Appeal) and Level 3 (External Independent Dental Review).

There are two types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has 3 levels. The appeals operate in similar fashion, except that expedited appeals are processed much faster because of a patients' condition.

### **Expedited Appeals**

*(For urgently needed service you have not yet received)*

Level 1	Expedited Dental Review
Level 2	Expedited Appeal
Level 3	Expedited External Independent Dental Review

### **Standard Appeals**

*(For non urgent services or denied claims)*

Informal Reconsideration
Formal Appeal
External Independent Dental Review

To submit a request for Formal Appeal, please send a written request to:

EDS Grievance and Appeals Coordinator  
P.O. Box 36600  
Tucson, AZ 85740-6600  
Phone: 1-800-722-9772  
Facsimile: (520) 696-4311

## **Need more information?**

After you enroll, a complete Formal Grievance and Appeals brochure will be mailed to your home with your ID card. To receive a copy of the formal Grievance and Appeals Brochure you may call our Customer Service Department at:

**Phoenix: (602) 248-8912**

**Tucson: (520) 696-4343**

**Statewide: 1-800-722-9772**



PLEASE PRINT

Contract Number		Effective Date	
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Address <i>(Complete Sections 1, 2, 3, 9)</i>		<input type="checkbox"/> Name Change <i>(Complete Sections 1, 2, 9)</i>	
<input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Add Dependent(s) <i>(Complete Sections 1, 2, 9, 11)</i>		Former Name: _____	
<input type="checkbox"/> COBRA Enrollment <input type="checkbox"/> Delete Dependent(s) <i>(Complete Sections 1, 2, 9, 11)</i>		<input type="checkbox"/> Change Dental Office <i>(Complete Sections 1, 2, 3, 4, 9)</i>	
(1) Employer / Company Name		Date Employed (mm/dd/yyyy)	(7) Home Telephone
(2) Your Name (Last, First, Middle Initial)		(8) Work Telephone	
(3) Mailing Address, City		Zip Code	(9) Social Security #
(4) Dental Office Selection For You And Your Enrolled Dependents:		(10) Date of Birth (mm/dd/yyyy)	
3-Digit Code		Name of Office	
(5) Do You Wish To Cover Your Eligible Dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No		(6) Total No. Of Dependents To Enroll	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

(11) LIST ALL ELIGIBLE DEPENDENTS YOU WISH TO ENROLL: Attach additional cards if necessary			
Last Name (if different) Spouse	First Name	Initial	Date of Birth
1. Child			
2. Child			
3. Child			
4. Child			

**Eligibility:** Eligible dependents will include lawful spouse and unmarried children to age 19, or any unmarried children to age 25, who attend an accredited educational institution on a full time basis and are fully dependent on employee for support or as stated in the employer's master contract. Participants may add dependents midyear if a marriage occurs. Participants may add dependents at date of employer group open enrollment. Dependent newborns or adopted children or children placed for adoption will be eligible immediately upon birth or upon adoption or placement for adoption. All newly eligible dependents must be added within 31 days of change. Dependent children must be deleted when they are no longer eligible.

**Benefits are available at your selected contracted dental facility ONLY.**

I hereby apply for coverage under EMPLOYERS DENTAL SERVICES for which I am now entitled or may become entitled under the provisions of the Master Agreement. I authorize deductions from my earnings at the required contributions towards the cost of the coverage. I certify that I am eligible to participate and that the above information is correct. I authorize any dentist or other dental care provider to furnish any representative of Employers Dental Services any and all records pertaining to dental history, services, or treatment of anyone enrolled for purposes of review, investigation, or evaluation of an application or claim. A photocopy of this authorization shall be valid as the original. This authorization shall remain valid for so long as my coverage remains in force. My authorized representative or myself are entitled to receive a copy of the authorizations form.

(Date) \_\_\_\_\_ (Signature) \_\_\_\_\_