



DENTAL PLAN OPTION FOR BEACHWOOD BOROUGH EMPLOYEES AND FAMILIES

FEATURES -----

NO DEDUCTIBLES
NO ANNUAL MAXIMUMS
NO CLAIM FORMS
NO COPAYS *

COVERS -----

PREVENTIVE CARE
RESTORATIVE CARE
ORTHODONTIC CARE*
PERIODONTIC CARE
and much more.

All services are available at Eastern Dental®, a provider of dental care for Dental Services Organization, LLC, a licensed Dental Provider Organization in the State of New Jersey.

Compare this Option with the examples of typical fees for dental services on the reverse side. Also, check our office locations for the one closest to you. Complete the enrollment form once you decide and return as instructed.

If you need any additional information about the DSO dental option call 1-800-982-5529 between 9:00 am and 4:30 pm and ask for the Beachwood Borough benefit representative.

** Some payments are required for Orthodontia.*

BEACHWOOD BOROUGH

Partial List of Services	Typical Fees	Cost With DSO Option
Periodic Exam	\$ 94.00	NONE
Cleaning (Adult)	\$ 175.00	NONE
Cleaning (Child)	\$ 120.00	NONE
Fluoride Treatment (up to age 19)	\$ 51.00	NONE
<u>Silver Fillings</u>		
1 Surface	\$ 260.00	NONE
2 Surfaces	\$ 320.00	NONE
<u>Root Canals</u>		
1 Root	\$1,299.00	NONE
2 Roots	\$1,494.00	NONE
<u>Gum Surgery</u>		
Osseous Surgery Per quadrant	\$2,137.00	NONE
<u>Crown - Individual</u>		
Pontic	\$1,823.00	NONE
<u>Dentures - Complete</u>		
Upper or Lower	\$3,174.00	NONE
<u>Dentures - Partial</u>		
Upper or Lower	\$3,199.00	NONE
<u>Orthodontic - Braces</u>		
Stainless Steel (Child)	\$5,890.00	\$500.00
Adult	\$5,890.00	\$1,250.00

<u>PROCEDURE</u>	<u>PATIENT COST</u>
DIAGNOSTIC	
Charting history, oral examination, periodic recall examination (every six months), emergency treatment	No Charge
RADIOGRAPHIC	
Complete intraoral series, periapical and bitewing films	No Charge
Intraoral periapical	No Charge
Each additional single film (periapical or bitewing)	No Charge
Occlusal view x-ray	No Charge
Lateral jaw x-ray, each	No Charge
Four bitewing x-ray films	No Charge
Antero-posterior x-ray of head and jaw	No Charge
Cephalometric radiograph	No Charge
Panoramic (panoraphy) including bitewings	No Charge
PREVENTIVE	
Oral prophylaxis (every six months)	No Charge
Topical fluoride treatment following prophylaxis (to age 19)	No Charge
Space maintainers – unilateral	No Charge
Space maintainers – bilateral	No Charge
OPERATIVE (RESTORATIVE) SERVICES	
Primary Silver amalgam – 1 surface	No Charge
Primary Silver amalgam – 2 surfaces	No Charge
Primary Silver amalgam – 3 surfaces or more	No Charge
Permanent Silver amalgam – 1 surface	No Charge
Permanent Silver amalgam – 2 surfaces	No Charge
Permanent Silver amalgam – 3 surfaces or more	No Charge
Silver amalgam reinforcement pins – 1 st	No Charge
Each additional pin	No Charge
Composite filling (for front teeth)	No Charge
Composite Class III	No Charge
Composite Class IV	No Charge
Core build-up (including any pins)	No Charge
PERIODONTIA	
Root scaling and root planing (per quadrant)	No Charge
Prophylaxis, medication and minor bite correction	No Charge
Gingivectomy, Gingivoplasty (per quadrant)	No Charge
Occlusal adjustment (and/or equilibration)	No Charge
Bite guard	No Charge
Osseous surgery (per quadrant)	No Charge
ENDODONTICS (INCLUDING RADIOGRAPHS)	
Single root canal, filling	No Charge
Double root canal, filling	No Charge
Triple or more root canal, filling	No Charge
Apicoectomy (per root)	No Charge
SIMPLE EXTRACTIONS (INCLUDING LOCAL ANESTHESIA)	
Single tooth	No Charge
Each additional tooth	No Charge
ORAL SURGERY EXTRACTIONS (INCLUDING LOCAL ANESTHESIA)	
Surgical extraction	No Charge
Extraction of tooth (soft tissue impaction)	No Charge
Extraction of tooth (partial bony impaction)	No Charge
Extraction of tooth (complete bony impaction)	No Charge
Alveoplasty/Alveolectomy (per jaw maximum) per quadrant in conjunction with extraction	No Charge
Alveoplasty, including ridge extension, arch	No Charge
Excision of benign tumor, lesion diameter up to 2.5 cm	No Charge
Removal of cyst up to 2.5 cm diameter	No Charge
PROSTHETICS (INCLUDING ADJUSTMENTS AND RELINES FOR 6 MONTHS FOLLOWING INSTALLATION) REMOVABLE	
Full upper denture	No Charge
Full lower denture	No Charge
Partial upper or lower denture without clasps, acrylic base	No Charge
Partial upper or lower denture with two chrome clasps with rests, acrylic base	No Charge
Partial upper or lower with chrome lingual or palatal bar with two clasps and rests, acrylic base	No Charge
Repair broken full or partial denture, no teeth damaged	No Charge
Repair broken full or partial denture, replace broken tooth	No Charge
Each additional tooth	No Charge
Replace broken tooth on denture, no other repairs	No Charge
Each additional tooth	No Charge
Adding tooth to partial denture to replace extracted tooth	No Charge
Each additional tooth	No Charge
Reattaching clasp on denture, clasp intact	No Charge
Replacing broken clasp with new clasp on denture	No Charge
Relining upper or lower full or partial denture (office) once every three years	No Charge
Relining upper or lower full or partial denture (lab) once every three years	No Charge
Jump case, complete denture (duplicate of denture) once every three years	No Charge

<u>PROCEDURE</u>	<u>PATIENT COST</u>
CROWNS	
Two surface gold inlay	No Charge
Three or more surfaces gold inlay	No Charge
Acrylic jacket	No Charge
Acrylic with metal (semi-precious)	No Charge
Porcelain jacket	No Charge
Porcelain fused to metal (semi-precious)	No Charge
¾ cast	No Charge
Full cast	No Charge
BRIDGES – PONTICS & ABUTMENTS (FIXED)*	
Cast	No Charge
Maryland bridge	No Charge
Porcelain fused to metal (semi-precious)	No Charge
Plastic processed to metal (semi-precious)	No Charge
*Refer to Exclusion #22	
ORTHODONTIC	
Maximum, 24 months (to age 19)	\$ 500.00
Adult (19 years or older)	\$ 1,250.00

LIMITATIONS AND EXCLUSIONS

BENEFITS shall not be provided for any of the following:

- Any dental services which were not rendered, prescribed, arranged, or approved by a Participating Dentist.
- Bedside calls, either at home or in a hospital.
- Any Hospital, outpatient or emergency facility administered anesthesia or any form of general anesthesia wherever administered, hospital charges, prescription drugs and/or laboratory tests.
- Consultation by Non-Participating Dentist(s) unless specifically directed by DSO.
- Any service or appliance for which the Covered Person incurs no charge.
- Any service or appliance not required in accordance with accepted standards of dental practice in the geographic area and/or location in which the service is provided.
- Any service or appliance received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or other similar person or group.
- Services provided under any governmental program (excluding the Medicaid Act), any state or federal worker's compensation, employer's liability or occupational disease law or similar law for loss covered by such benefits; and services performed by a member of a Member's immediate family.
- Anything other than services enumerated in this Contract.
- 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 of any State of the United States or of any Foreign country or of any political subdivision of any of the foregoing.
- Dental services rendered prior to the date the Enrollee or Covered Person became eligible for such services under this Contract.
- Any service(s) or item(s) which are determined by DSO's Dental Director, prior to being provided, not to be a necessary service or item incidental to the condition, disease or injury for which the Covered Person is being treated.
- Broken appointments. An Enrollee may be liable for charges for broken appointments consistent with and if that is the policy of the provider office.
- Any dependent(s) below age ten (10) where such dependent is so unruly as to make the rendering of services impractical under the circumstances in the opinion of the Participating Dentist.
- Treatment of unmanageable patients. An attempt will be made to treat all patients; however, if a Covered Person is untreatable by virtue of fear or phobia, it is the Enrollee's responsibility to contact DSO and discuss possible referral to another office for treatment at the Enrollee's expense.
- Treatment of a Covered Person with a communicable disease without medical clearance from such person's physician.
- Services/supplies partially or wholly cosmetic in nature, including bleaching, bonding procedures and orthodontic services and appliances.
- Replacement of any lost, stolen or existing prosthesis made within five (5) years.
- Prosthetic devices, including but not limited to bridges, crowns, inlays, complete and partial removable dentures for which the final impressions were taken while the Covered Person was not Covered under this Plan; or where final impressions were taken while such Covered Person was covered under this Plan, but not finally installed or delivered to such Covered Person within sixty (60) days after termination of coverage.
- Replacement of an orthodontic appliance including retainers, bite plates, functional appliances, lingual arches and tongue cribs or repair due to patient negligence.
- Dental procedure(s) required because of insurrection, invasion, bombardment, rebellion, revolution, military or usurped power or riot or resulting from any type of accidental injury, whether or not due to or caused by negligence, act of God, deliberate conduct of any kind or caused by anything other than natural biological factors, improper, poorly performed or nonexistent dental hygiene or by reason of dental (including periodontal) disease.
- Replacement of teeth by fixed bridgework where teeth are missing on both sides of the same arch or jaw. Where teeth are missing on both sides of the same arch, replacement will be accomplished by removable prosthesis.
- Expenses for duplication, maintenance or repair of any appliance to be used as a spare.
- Expenses for all periodontal regenerative therapy and appliances or restorations necessary to accomplish periodontal splinting, increase vertical dimensions or restore occlusion.
- Expenses for occlusal equilibration except to the extent necessary to treat periodontal disease.
- Expenses for implantology, sealants or mouthguards.
- Treatment of major congenital defects, such as cleft palates, and associated deformities and temporomandibular joint dysfunction.
- Repairs to a removable denture which is (i) at least five (5) years old;(ii) to be replaced; (iii) beyond repair; and (iv) no longer serviceable.

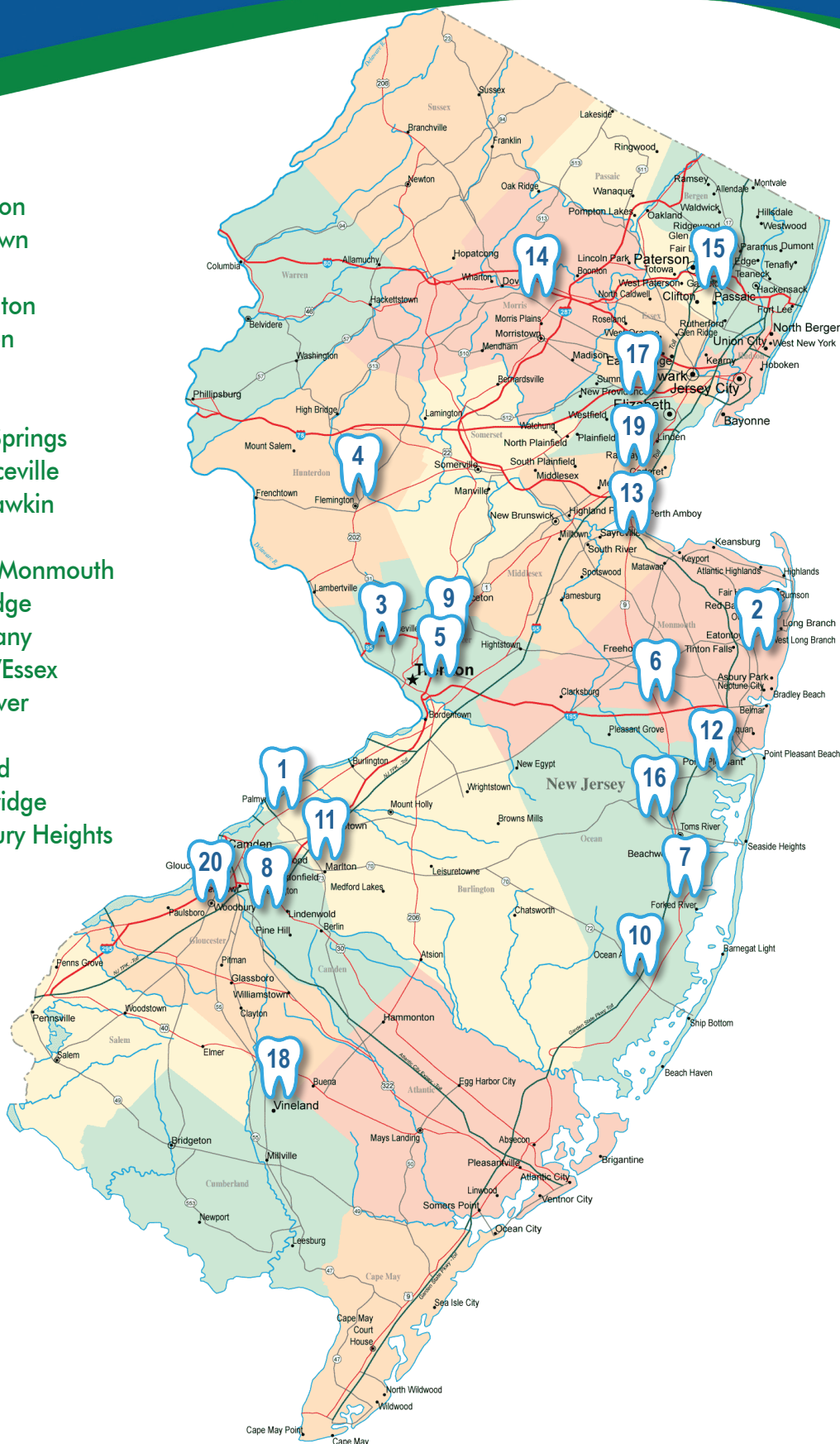


Dental Services Organization, LLC

PROVIDER
OFFICES

1. Eastern Dental® of Burlington
2. Eastern Dental® of Eatontown
3. Eastern Dental® of Ewing
4. Eastern Dental® of Flemington
5. Eastern Dental® of Hamilton
6. Eastern Dental® of Howell
7. Eastern Dental® of Lacey
8. Eastern Dental® of Laurel Springs
9. Eastern Dental® of Lawrenceville
10. Eastern Dental® of Manahawkin
11. Eastern Dental® of Marlton
12. Eastern Dental® of Ocean/Monmouth
13. Eastern Dental® of Old Bridge
14. Eastern Dental® of Parsippany
15. Eastern Dental® of Passaic/Essex
16. Eastern Dental® of Toms River
17. Eastern Dental® of Union
18. Eastern Dental® of Vineland
19. Eastern Dental® of Woodbridge
20. Eastern Dental® of Woodbury Heights

**Offering
managed care
dental plans
throughout
New Jersey
for over
30 years.**





PROVIDER OFFICES

Eastern Dental® of Burlington

(856) 303-0600

Pep Boys Plaza
202 Route 130 North
Cinnaminson, NJ 08077-3304

Eastern Dental® of Eatontown

(732) 660-0500

1802 Route 35 South
Oakhurst, NJ 07755-2912

Eastern Dental® of Ewing

(609) 883-0801

1330 Parkway Avenue
Ewing, NJ 08628-3091

Eastern Dental® of Flemington

(908) 237-2100

433 US Highway 202
Flemington, NJ 08822-6041

Eastern Dental® of Hamilton

(609) 587-0600

2103 Whitehorse-Mercerville Road
Hamilton, NJ 08619-2694

Eastern Dental® of Howell

(732) 683-1130

2346 Route 9 South
Howell, NJ 07731-4017

Eastern Dental® of Lacey

(609) 693-6066

131 South Main Street (Route 9)
Forked River, NJ 08731-3635

Eastern Dental® of Laurel Springs

(856) 784-5100

3 Kelly Drivers Road
Laurel Springs, NJ 08021-4823

Eastern Dental® of Lawrenceville

(609) 587-6300

520 Lawrence Square Boulevard
South Lawrenceville, NJ 08648-2674

Eastern Dental® of Manahawkin

(609) 489-0030

733 Route 72 East
Manahawkin, NJ 08050-2864

Eastern Dental® of Marlton

(856) 983-5400

951 Route 73 North, Suite A
Marlton, NJ 08053-3211

Eastern Dental® of Ocean/Monmouth

(732) 477-9200

Kennedy Plaza
2770 Hooper Avenue, Unit 4
Brick, NJ 08723-4108

Eastern Dental® of Old Bridge

(732) 727-3399

Sayrebrook Towne Center
2909 Washington Road, Suite 135
Parlin, NJ 08859-1513

Eastern Dental® of Parsippany

(973) 292-2550

Powder Mill Plaza West
2936 Route 10 West
Morris Plains, NJ 07950-1244

Eastern Dental® of Passaic/Essex

(973) 478-9300

600 Getty Avenue
Clifton, NJ 07011-1915

Eastern Dental® of Toms River

(732) 286-7020

1228 Route 37 West
Toms River, NJ 08755-4922

Eastern Dental® of Union

(908) 964-5406

2115 Route 22 West
Union, NJ 07083-8403

Eastern Dental® of Vineland

(856) 692-5400

1145 East Chestnut Avenue
Vineland, NJ 08360-5001

Eastern Dental® of Woodbridge

(732) 750-3600

1030 St. Georges Avenue
Avenel, NJ 07001-1327

Eastern Dental® of Woodbury Heights

(856) 845-7775

1006B Mantua Pike, Suite 1
Woodbury Heights, NJ 08097-1228



Dental Services Organization, LLC

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Avenel, NJ 07001 • 1(800) 982-5529





GROUP USE ONLY

(Please Print)

Last Name of Applicant		First Name	Middle Initial	Phone No.	Male ☐	Married ☐	Effective Date		
					Female ☐	Single ☐			
Street Address		City	State & ZIP		Date of Birth	Month	Day	Year	Group Number
Name of Employer		Date of Employment		Social Security Number					

DEPENDENT INFORMATION — List Spouse and Unmarried Children

Name of Dependent	Relationship	Date of Birth	Name of Dependent	Relationship	Date of Birth

FROM THE LIST OF PARTICIPATING PROVIDERS,
SELECT A DENTAL OFFICE TO BE YOUR
PRIMARY DENTAL CARE PROVIDER AND ENTER
THE NAME BELOW.

Name of Provider Office

I hereby represent to you that all information furnished by me on this application is true and complete to the best of my knowledge.

Signature of Applicant

Date Signed