Integrity Outsource
Dental Insurance

Effective 7/1/2021- 6/30/2022

	PPO In-Network	PPO Out-of-Network
Class I Preventative	100%	100% MPR
Class II *Basic	90%	80% MPR
Class III *Major	60%	50% MPR
Class IV Orthodontics	Ortho Edge	No Coverage
Annual Maximum	$1,500.00	
Ortho Lifetime Maximum	Based Upon Fee Schedule Adults and Children	
Endodontics Periodontics	Class II Class III	
*Deductible	$50.00/$150.00	
Waiting Periods	None	None
Employee EE + 1 EE + Family	$53.16 $97.84 $151.96	

	EPO In-Network	
Class I Preventative	100%	
Class II *Basic	80%	
Class III *Major	50%	
Class IV Orthodontics	Ortho Edge	
Annual Maximum	$1,000.00	
Ortho Lifetime Maximum	Based Upon Fee Schedule Adults and Children	
Endodontics Periodontics	Class III	
*Deductible	$50.00/$150.00	
Waiting Periods	None	None
Employee EE + 1 EE + Family	$42.02 $76.38 $118.12	

	Select Provider DHMO Summit Care Plus - Arizona ONLY In-Network	
Class I Preventative	Per Schedule (Approx. 100%)	
Class II Basic	Per Schedule (Approx. 80%)	
Class III Major	Per Schedule (Approx. 55%)	
Class IV Orthodontics	Ortho Edge	
Annual Maximum	Unlimited	
Ortho Lifetime Maximum	Based Upon Fee Schedule Adults and Children	
Endodontics Periodontics	Based Upon Fee Schedule	
Deductible	None	
Waiting Periods	None	N/A
Employee EE + 1 EE + Family	$20.39 $36.23 $52.26	

TDA network in AZ, Dentemax network nationwide for the PPO and EPO plans. The DHMO is only valid in AZ and you must choose a TDA provider.
For a provider listing use: www.TDAdental.com or www.dentemax.com or call 602-266-1995

Specialists	Paid same as General Dentist	Paid same as General Dentist	Same copay as General Dentist
Exams	2 in twelve months	2 in twelve months	2 in twelve months
Cleaning	1 every 6 months	1 every 6 months	1 every 6 months
Fluoride	Children up to age 19	Children up to age 19	Children up to age 15
Bitewing X-ray	1 every 6 months	1 every 6 months	1 every 6 months
Panoramic X-ray	1 every 3 years **Sealants**	1 every 3 years	1 every 3 years
	Children up to age 17	Children up to age 17	Children up to age 17
Space Maintainers	Covered under Class 1	Covered under Class 1	See Fee Schedule

TDA
Total Dental Administrators

GROUP DENTAL ENROLLMENT FORM

☐ New Employee ☐ Add/Delete Dep. ☐ Transfer from DHMO ☐ Cancel Coverage ☐ COBRA Enrollment
☐ Open Enrollment ☐ Rehire ☐ Address/Name Change ☐ Loss of Other Coverage ☐ Transfer from PPO

Name of Employer:	Group Numbers:	Divison:
Integrity Outsource, LLC	2267AZH2651250/EHA-AZH26991	

Plan Types:

☐ DHMO Dental Plan #_____ Dental Office Selected ☐ EPO Dental Plan ☐ PPO Dental Plan

Social Security Number:	Effective Date Mo / Day / Year	Date Employed Full Time Month / Day / Year	Hours Worked Per Week

Last Name:	First Name:	MI:	Date of Birth Month / Day / Year	Sex: Male ☐ Female ☐

Home Address:

Street:_____

Apartment # _____

City, State, Zip:_____

Home Phone:_____ **Work Phone:** _____

Do you have other Dental Coverage? If yes, Carrier:

Coverage Requested:

☐ Employee Only

☐ Employee + 1 Dependent

☐ Family

Complete for Dependent Coverage:

Do any of your dependents have other dental coverage? If yes, list Carrier below

	Spouse Name-Last:	First:	MI:	Sex:	Date of Birth:	Name of Other Dental Carrier:
					/ /	
CHILDREN	1.				/ /	
	2.				/ /	
	3.				/ /	
	4.				/ /	
	5.				/ /	
	6.				/ /	

I ELECT THE DENTAL COVERAGE selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my employer to deduct the contribution from my wages. I hereby apply for enrollment and agree to remain in the Plan a minimum of one year, authorize the release of any information relating to dental care received under the Plan, and to all terms and conditions set forth in the Group Agreement.

Date: **Employee Signature:**

REFUSAL OF GROUP DENTAL COVERAGE: I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Date: **Employee Signature:**

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TDA
Total Dental Administrators

ORTHODONTIC EDGE

THIS PROGRAM IS NOT INSURANCE ♦ THIS PROGRAM IS A POINT OF SALE DISCOUNT PLAN

TDA has contracted with established Orthodontists in Arizona to provide comprehensive Orthodontic Dental Care at substantial savings for children and adults in accordance with the following TDA ORTHODONTIC EDGE PLAN Schedule of Services and Co-payments.

YOU MUST VISIT AN ARIZONA TDA CONTRACTED PROVIDER IN ORDER TO RECEIVE SERVICES.

To obtain orthodontic dental services, refer to the TDA Directory of Participating Orthodontists or you may receive facility information by calling TDA at (602) 266-1995 or by visiting our Web site at www.TDADental.com.

To schedule an appointment, contact a Participating Orthodontist's Office convenient for you and identify yourself as a TDA Plan member.

All Payments listed under the Schedule of Services and Co-payments are made, by the member, directly to the orthodontic office. You should discuss all future payments and costs before new appointments are made. The Dental Office staff will help you plan your orthodontic treatment and payments.

Orthodontic Edge Schedule of Services and Co-Payments

ORTHODONTICS	Patient/Total Co-payment
D8999 Screening exam	No Charge
D8999 Diagnostic Workup, x-rays/models	$ 200.00
D8030 Limited orthodontic treatment (child under age 19)	$ 2,800.00
D8040 Limited orthodontic treatment (adult/age 19 & over)	$ 3,200.00
D8080 Comprehensive orthodontic treatment (child under age 19)	$ 3,400.00
D8090 Comprehensive orthodontic treatment (adult/age 19 & over)	$ 3,700.00
D8210 Removable appliance therapy	$ 700.00
D8220 Fixed appliance therapy	$ 700.00
D8660 Pre-orthodontic treatment visit	$ 45.00
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$ 150.00
D8691 Repair of orthodontic appliance	$ 50.00
D8692 Replacement of lost or broken retainer	$ 150.00
D8999 Final orthodontic records	$ 100.00

*Procedures or services not listed may be provided at usual & customary fees

ORTHODONTIC PLAN EXCLUSIONS AND LIMITATIONS

1. No benefits will apply for a treatment program that began before the Member/Subscriber enrolled in the Orthodontic Plan.
2. No benefits will apply for lost or broken appliances, except as provided herein.
3. Extractions for orthodontic purposes are not included as a benefit.
4. No benefit will apply for the following:
   a. Care required in excess of 24 months from the time of banding.
   b. Gross non-cooperation.
   c. Accidents occurring during the period of treatment.
   d. Cases involving surgical orthodontics.
   e. Cases involving myofunctional therapy or T.M.J.
5. If the Member and/or Subscriber relocate to an area and is unable to receive treatment from a member orthodontist, coverage under the Plan ceases and it becomes the obligation of the Member and/or Subscriber to pay the usual and customary fee of the Orthodontist where the treatment is completed.
6. Choice of Orthodontist is limited to Orthodontists participating in the Plan or to Orthodontists who will accept the fees outlined in the Plan.
7. If the Member and/or Subscriber become ineligible for benefits under this Plan for treatment, coverage under the Plan ceases and it becomes the obligation of the Member and/or Subscriber to pay the remaining balance due the Orthodontist.