Voluntary Dental Benefits Summary
Premier Option VB3X50

How To Use this Dental Plan

When you visit your dental provider, tell him or her you are a member of an ODS dental program.

Calendar year maximum, per member	**$1,500**
Calendar year deductible, per member	**$50**
Calendar year maximum deductible, per family	**$150**

Service	Benefit Amount
PREVENTIVE* - Periodic Examinations / X-rays - Prophylaxis (cleanings) / Periodontal Maintenance - Sealants - Space Maintainers - Topical Application of Fluoride	**100%**
BASIC - Restorative Fillings	**80%**
MAJOR (Services subject to a 12-month exclusion period) - Oral Surgery (extractions & certain minor surgical procedures) - Endodontic (treatment of teeth with diseased or damaged nerves) - Periodontics (treatment of diseases of the gums and supporting structures of the teeth) - Crowns and other cast restorations - Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	**50%**

*** Deductible waived for preventive services**

Advantages

* **Freedom to choose your dentist** ODS offers a large network of dentists, having over 2,000 contracted licensed dentists in Oregon participating in our Delta Dental Premier network. As the Delta Dental Plan of Oregon, we offer access to over 139,000 Delta Dental Premier dentists nationwide.
* **Professional Arrangements** ODS and other Delta Dental member companies have specific negotiated fees with our participating dentists to ensure that actual charges made by the dentist do not exceed his or her accepted or contracted fees on file. We believe that the underlying unique feature inherent to all ODS programs is every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to ODS for you.
* **myODS is** a customized member website with current, accurate and easy to understand information about your plan. Log onto www.odscompanies.com/members to access myODS.

Dependent Eligibility

Dependents are lawful spouse, Oregon registered domestic partners and eligible children to age 26, including children an employee is required to enroll due to a court or administrative order.

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LIMITATIONS

If a more expensive treatment than is functionally adequate is performed, ODS will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class I Services)

* **Diagnostic** Routine or comprehensive examinations or consultations covered once in any 6-month period. Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.
* **Preventive** Prophylaxis (cleaning) or periodontal maintenance limited to once in any 6-month period. Topical application of fluoride is covered once in any 6-month period for members until age 19. For members age 19 and older, topical application of fluoride is covered once in any 6-month period if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period.

Basic (Class II Services)

* **Restorative** If a tooth colored filling is used to restore posterior (back) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference. A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.

Major (Class III Services)

* **Oral Surgery** Limited to extractions and other minor surgical procedures.
* **Restorative** Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth.
* **Periodontic** Scaling and root planing is limited to once per quadrant in any twenty-four (24) month period.
* **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.

EXCLUSIONS

* Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
* Services with respect to congenital or developmental malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis and disturbance of the temporomandibular joint.
* Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
* Services started prior to the date the individual became eligible for services under the program.
* Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
* Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
* General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
* Plaque control and oral hygiene or dietary instructions.
* Experimental procedures.
* Missed or broken appointments.
* Precision attachments.
* Orthodontic services.
* Implants
* Services for cosmetic reasons.
* Claims submitted more than 12 months after the date of service are not covered.
* All other services or supplies, not specifically covered.

This is a benefit summary only.
For a more detailed description of benefits, refer to your member handbook.
Visit our website at www.odscompanies.com

DELTA DENTAL

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