Dental Plan 4 with Orthodontia
Oregon Educators Benefit Board

Effective October 1, 2012

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.

Plan year (10/1 - 9/30) maximum, per member	**$1,500**
Plan year (10/1 - 9/30) deductible, per member	**$50**

Service	Benefit Amount
PREVENTIVE - Deductible waived	
- Periodic Examination/X-rays - Prophylaxis (cleanings) / Periodontal Maintenance - Topical Fluoride Application (18 and under/high risk) - Sealants - Space Maintainers	**100%**
RESTORATIVE	
- Restorative Fillings (posterior teeth paid to amalgam fee) - Oral Surgery (extractions & certain minor surgical procedures) - Endodontics - Periodontics (treatment of diseases of thegums and supporting structures of the teeth) - Brush Biopsy (once in 6 month period) - Extractions	**80%**
MAJOR	
- Crowns - Onlays	**80%**
PROSTHODONTIC	
- Implants - Bridges - Denture and Bridge Work (construction or repair of fixed bridges, partials and complete dentures) - Prosthodontics	**50%**
Pre-determination As a service to our customers, your dental office can submit a pre-treatment plan to ODS on your behalf, and we will return it to them indicating the dollar allowance which will be covered by your plan before you go forward with treatment.	
ORTHODONTICS	
- For eligible members and their covered dependents	**80% up to a $1,800 lifetime maximum**

Orthodontic services are a benefit for eligible employees and their dependents. These services are defined as the procedures of treatment for correcting malocclusioned teeth.

The Plan will pay 80% of the participating orthodontist's charge for orthodontic services, up to the maximum benefit.

The amount payable to a non-participating orthodontist will be the lesser of 80% of the orthodontist's fees, or 80% of the median of all participating orthodontists' filed fees with ODS.

The maximum amount the Plan will pay for orthodontic services for a covered patient is $1,800.

This is a benefit summary only. Any errors or omissions are unintentional.
For a more detailed description of benefits, refer to your member handbook.

Visit ODS' web site at www.odscompanies.com/oebb

See reverse side of document for additional information.

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ADVANTAGES

DELTA DENTAL

* **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 131,000 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.
* **Dental Optimizer™** is a free resource on myODS that enables you to assess your risk level for oral health concerns and use that assessment to learn about reducing your risks and treatment costs. Dental Optimizer is comprised of a cavities risk assessment, dental health suggestions, and a Savings Optimizer based on a personal survey.
* **myODS** is a customized member website with current, accurate and easy to understand information about the member's plan. Log onto www.odscompanies.com/oebb to access myODS.

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. 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.

Preventive (Class I Services)

* **Diagnostic** Routine examination and bitewing x-rays limited to once every six (6) months. Full mouth x-rays limited to once every (3) years.
* **Preventive** Prophylaxis (cleaning) or periodontal maintenance limited to once every six (6) months. Topical application of fluoride is covered once every six (6) months for members age 18 and under. For members age 19 and up, topical application of fluoride is covered once every six (6) month period if there is a recent history of periodontal disease or high risk of decay. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any five (5) year period.

Basic (Class II Services)

* **Oral Surgery** Limited to *extractions and other minor surgical procedures*.
* **Restorative** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
* **Periodontic** Scaling and root planning is limited to once per quadrant in any twenty-four (24) month period.

Major (Class III 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. Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth.

Prosthodontic (Class IV Services)

* **Implants** and implant removal are limited to once per lifetime per tooth space. A crown over an implant is covered
* **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
* Plaque control and oral hygiene or dietary instructions.
* Experimental procedures.
* Missed or broken appointments.
* 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.