



## ORAL HEALTH SAVINGS PLAN

**For Individuals and Families**

Our solution for making quality dental care affordable and accessible for your entire family.

**Spodak**  
dental group

DEDICATED TO YOUR SMILE

## A DENTAL PLAN TO SMILE ABOUT

At the Spodak Dental Group, we recognize that quality dental care is presently beyond the reach of millions of Americans. To offset the spiraling costs of care, we have developed the Oral Health Savings Plan. Now, with the convenience of controlled costs and extended hours, world-class dental care is even more affordable and accessible than ever.

## THE PLAN AT A GLANCE

Adult One-Year Membership	\$227*
Additional Family Member <i>(Spouse and/or dependent)</i>	\$119*

Annual Membership includes:

- **Two regular check-ups per year**  
\$95 value D0150/D0120
- **Two regular cleanings per year**  
(healthy gums)  
\$170 value D01110
- **All necessary X-rays, including:**
  - **Full-mouth series and/or Panoramic** (once per 3 years)  
\$137 value D0210/D0330
  - **Bite wings** (once per year)  
\$75 value D0274
- **10% – 40% savings** on all restorative, cosmetic, endodontic, prosthodontic, orthodontic and surgical services

\*After the first year, the plan is renewable, without lapse, at a 10% discount. Additional family members added prior to the plan's annual anniversary will be charged the full annual membership fee. Prorated fees do not apply. The option for renewal will be based upon the primary member's anniversary date.

Value Comparison Applicable Services	Our Plan	Traditional Insurance*
Maximum Benefit	none	\$1000-2000
No-Charge Preventive Care	✓	✓
Regular Cleanings (for healthy teeth and gums)	✓	✓
Necessary X-rays	✓	✓
Orthodontics	✓	✓
Cosmetic Services	✓	∅
Specialist Services	all	some
Access to On-Site Laboratory (for custom restorations)	✓	n/a
MD-Supervised IV Sedation	✓	∅
Unrestricted Choice of Dentist	✓	∅
Courtesy Adjusted Fees	15-40%	∅
No Pre-approval	✓	∅
No Pre-Existing Condition Exclusions	✓	∅
No Deductibles	✓	∅
No Waiting Period	✓	∅
No Claim Forms	✓	∅
Continuous Open Enrollment	✓	∅

\*Comparisons to other dental membership plans and traditional insurance plans are hypothetical and are based on typical coverage. They are not intended to be construed as comprehensively representative of all plans or dental policies.

## PAYMENT POLICY

In order to offer the substantial procedure fee courtesies available under the terms of this plan, we must adhere to the following payment policies:

- The one-year membership must be paid in full at the time of enrollment.
- The membership will be valid for one year from the date the annual fee is remitted.
- All treatment fees are due and payable at the time service is rendered.
- All fees for treatment requiring multiple visits or lab fees are due upon the first visit.
- A \$100 deposit will be required to reserve appointment time for any specialty service—a cancelled appointment fee and/or forfeiture of the appointment deposit will apply to any appointment cancelled without at least 48 hours prior notice.
- Spodak Dental Group reserves the right to refuse treatment and/or terminate this membership without notice if the member's account becomes delinquent at any time. All other Spodak Dental Group terms and conditions of service apply.

## EXCLUSIONS

Procedure fee courtesies offered under this plan shall not apply to any treatment already in process prior to enrollment in the plan and may not be combined with dental insurance benefits, any other discounts, promotions or in-house financing plans. This is not a dental insurance plan; benefits are limited to treatment provided through the Spodak Dental Group.

# Membership Fee Schedule

## General Dentistry

### Diagnostic D0100-D0999

Two Dental Cleanings (healthy gums), Oral Exam, Periodontal Evaluation, Oral Cancer Screening, Unlimited Digital X-Rays	no charge
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3D Imaging	10% off
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Emergency Exam	\$27
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### Preventive D1000-D1999

Routine Adult D1110 / Child D1120 Cleanings (twice per year) and All Other Preventive Services (healthy gums)	no charge
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### Periodontics D4000-D4999

Periodontal "Deep" Cleanings (unhealthy gums) and Minor Periodontal Procedures	20% off
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### Routine Restorative D2000-D2957

White Fillings, Inlays, Onlays, Single Crowns, Crown Build-Ups	20% off
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### Cosmetic Restorative D2740, D2783, D2960-D2962

Porcelain Veneers, Crowns (placed over otherwise healthy teeth for elective cosmetic improvement)	15% off
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### Endodontics D3000-D3999

Pulpotomies, Pulpectomies, Removal of Nerve, Root Canal Therapy	20% off
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### Prosthodontics (Removable) D5000-D5999

Partials, Complete Dentures, Denture Repairs and Adjustments	20% off
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**Prosthodontics  
(Fixed/Non-Removable)**

D6200-D6999

Permanent Bridges (retained by  
crowns or inlays/onlays)

20% off

**Implant Supported  
Prosthodontics**

D6055-D6199

Crown, Permanent Bridges, Removable  
Bridges (supported or retained by implants)

15% off

**Oral Surgery**

D7000-D7999

Simple Extractions of Teeth (including  
some impacted wisdom teeth)

40% off

**Invisalign®**

D8000-D8999

Invisalign®, Invisalign Teen®, Invisalign Express®,  
Orthodontic Retainers

15% off

**Anesthesia**

D9210-D9248

Sedation Dentistry, Sleep Dentistry

15% off

**Treatment By A Specialist**(Performed by or under supervision of a specialist dentist or  
medical professional)**Diagnostic**

D0100-D0999

X-rays

no charge

Examinations and Consultations

50% off

**Endodontics**

D3000-D3999

15% off

**Periodontics**

D4000-D4999

15% off

**Implants**

D6000-D6199

10% off

**Oral Surgery**

D7000-D7999

20% off

**Sleep Dentistry** (with our  
MD anesthesiologist)

D9210-D9248

10% off

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ SS#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_

Plan Option:  **Adult One-Year Membership (\$227)**  **Family One Adult (\$227) + (\$119 x # \_\_\_\_\_) of Additional Family Members**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Amount of Payment: \$ \_\_\_\_\_ Card Type:  Visa  MasterCard  AmEx

Payment Option:  Check Enclosed  Bill My Credit Card Card # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

I understand and accept all terms and conditions of the Spodak Dental Group Oral Health Savings Plan as summarized in this brochure and hereby authorize the Spodak Dental Group to charge my credit card (if applicable) as indicated above, for the payment of my membership: \_\_\_\_\_ Date

Member Signature

Mail or bring completed form to: Spodak Dental Group, 4665 W. Atlantic Avenue, Delray Beach, FL 33444

phone: **561-498-0050** fax: **561-498-0841** website: **www.spodakdental.com** email: **inform@spodakdental.com**

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561-498-0050 • [www.spodakdental.com](http://www.spodakdental.com)