Dental Plus of Idaho Benefit Summary

For Services by a Participating Dentist

Benefit	Copayment
Annual Maximum	No Annual Maximum
Deductible	No Deductible
Office Visit	$0
Dental Exams	$20
X-rays	$20
Teeth Cleaning (adult)	$50
Fluoride Treatment	$15
Sealants per Tooth	$30
Fillings	$50
Stainless Steel Crown	$70
Porcelain Fused to Metal Crown[1]	$300
Complete Denture[1]	$425
Bridge (per tooth)[1]	$300
Root Canal Therapy – Anterior / Bicuspid / Molar	$200
Osseous Surgery Per Quadrant	$250
Root Planing Per Quadrant	$50
Routine Extraction	$50
Surgical Extraction	$100
Pre-Orthodontic Service[1 2]	$150
Comprehensive Orthodontia[1]	$3,000
Nitrous Oxide Per Visit	$20

[1] Benefit available after a six month waiting period.

[2] Applies toward comprehensive orthodontic copayment if patient accepts treatment plan.

Services from a Non-Participating Provider are reimbursed $10. The enrollee is responsible for all other charges and fees charged by the Non-Participating Provider, to the extent such amount exceeds $10.

Underwritten by Willamette Dental of Idaho, Inc. This is a summary of common procedures covered in the Dental Plus of Idaho plan. The policy will control. Please refer to the policy for a complete description of benefits, limitations, and exclusions.

Premium Rates

Premiums are paid on a monthly basis. Payment may be made by personal or cashier's check, money order, Auto Pay (checking account deduction) or credit card (Visa, Mastercard, Discover).

	Monthly Rate
Member Only	$63.20
Member & Spouse or Domestic Partner	$126.41
Member & Children	$120.09
Family	$217.42

***Rates are valid for 12 months from effective date.*

Dental Plus of Idaho Summary of Exclusions

Please refer to your policy for a complete description of copayments, exclusions and limitations.

- Bridges, crowns, dentures or prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.
- The completion or delivery of treatments or services initiated prior to the effective date of coverage.
- Dental implants.
- Endodontic services, prosthetic services, and implants provided prior to the effective date of coverage.
- Endodontic therapy completed more than 60 days after termination of coverage.
- Experimental or investigational services.
- Exams or consultations needed solely in connection with a service or supply that is not covered.
- Full mouth reconstruction.
- General anesthesia, moderate sedation, or deep sedation.
- Hospital care or other care outside of a dental office or facility fees.
- Maxillofacial prosthetic services.
- Nightguards.
- Orthognathic surgery.
- Personalized restorations.
- Plastic, reconstructive, or cosmetic surgery, except as covered to correct congenital anomalies in children.
- Prescription and over-the-counter drugs and pre-medications.
- Replacement of lost, missing, stolen or damaged dental appliances.
- Replacement of sound restorations.
- Services and related exams or consultations that are not within the prescribed treatment plan, are not recommended and approved by a Participating Dentist or are not necessary.
- Services by any person other than a licensed dentist, denturist, hygienist, or dental assistant.
- Services for the diagnosis or treatment of temporomandibular joint disorders.
- Services for the treatment of an occupational injury or disease.
- Services for treatment of injuries sustained while practicing for or competing in a professional athletic contest of any kind.
- Services for treatment of intentionally self-inflicted injuries.
- Services for which coverage is available under any federal, state, or other governmental program.
- Services that are not included in the appendices to the policy.
- Services where there is no evidence of pathology, dysfunction, or disease.