

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
Member Only	\$55.87
Member & Spouse or Domestic Partner	\$111.73
Member & Children	\$106.15
Family	\$192.18

*Rates are valid for 12 months from effective date.

Contact Us

For questions about your bill, to make a payment or to find out the status of your application, please call:

1.855.998.2273, Option 1

If you are not a member yet and have questions about our insurance plan options, please call:

1.855.998.2273, Option 2

To schedule an appointment, please call:

1.855.998.2273, Option 3

For answers to frequently asked questions, visit our website at:

willamettedental.com/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 Tooth	\$200
– Bicuspid Tooth	\$200
– 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.