DENTAL PLUS OF IDAHO

The Dental Plus of Idaho plan is a managed care dental policy and is underwritten by:
Willamette Dental of Idaho, Inc.
6950 NE Campus Way, Hillsboro, OR 97124

THE POLICY PROVIDES DENTAL BENEFITS ONLY.

005DPID(1/20)
Policy Form No. 001DPID(1/20)

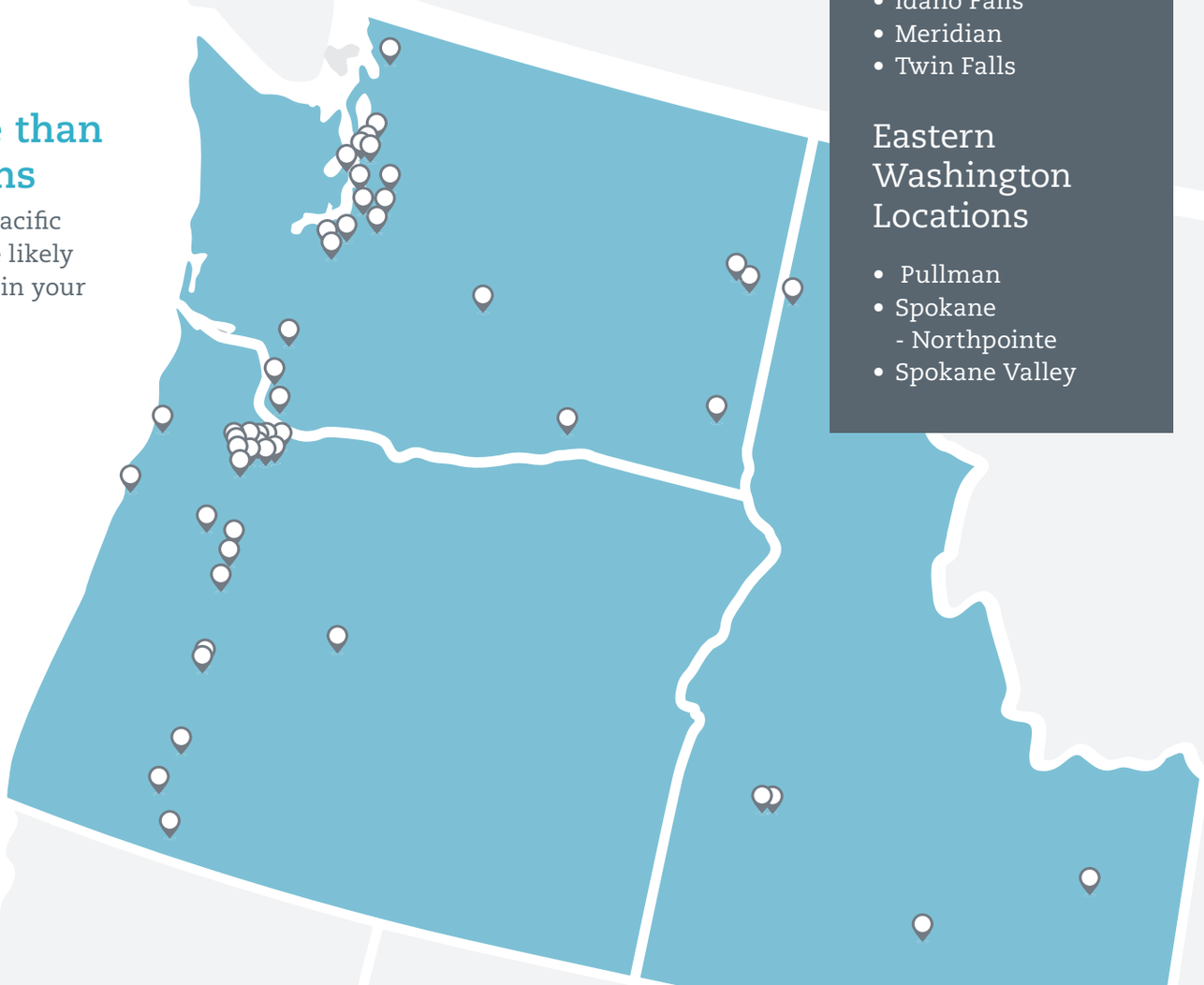
Willamette Dental Group

Personal care
for your individual needs

Willamette Dental of Idaho, Inc. is pleased to offer you Dental Plus of Idaho. This plan is true individual dental insurance that will provide coverage for your dental care needs. There is no maximum to the amount of dental services that this plan will cover and there are no deductibles that need to be met. Your coverage gives you simple access to dental care.

With more than 50 Locations

throughout the Pacific Northwest, we're likely to have an office in your neighborhood.



Idaho Locations

- Boise
- Coeur d'Alene
- Idaho Falls
- Meridian
- Twin Falls

Eastern Washington Locations

- Pullman
- Spokane
  - Northpointe
- Spokane Valley

To receive benefits, you must receive your care at a Willamette Dental Group, P.C., dental office. An advance appointment is required to receive care. To schedule your dental appointments, call our Appointment Center at 1.855.433.6825, Option 1. When you speak to a Willamette Dental Group representative or arrive at the dental office for your appointment, simply identify yourself as a Dental Plus of Idaho member. You will then receive dental care in accordance with your policy.

Most dental offices are open Monday through Friday, 7 AM to 6 PM, and occasional Saturdays.

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.

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.*

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.

Dental Plus of Idaho Enrollment Application

Willamette Dental Group

You are eligible for individual coverage under the Dental Plus of Idaho plan if you are an Idaho resident and are at least 18 years of age. Your eligible dependents include your spouse or domestic partner, child, and spouse's or domestic partner's child. Members may not be enrolled under any other insurance plan issued or offered by Willamette Dental of Idaho, Inc. or its affiliates.

To enroll in the Dental Plus of Idaho plan, complete both sides of this application, including your signature on the back. Please mail the completed application and premium payment to the address below.

Willamette Dental of Idaho, Inc.
Dental Plus of Idaho
6950 NE Campus Way
Hillsboro, OR 97124

If we receive your application and premium payment between the 1st and 25th of the month, your coverage will be effective on the first day of the following month. If paying by Auto Pay or credit card, application and payment can be submitted by fax or email to 503-952-2679 or dpi@willamettedental.com.

1 Plan Selection (Select One)

		Monthly
☐	Member Only	$63.20
☐	Member & Spouse/Partner	$126.41
☐	Member & Children	$120.09
☐	Member, Spouse/Partner & Children	$217.42

2 Premium Payment – Please Select Auto Pay or Check

☐ Auto Pay via checking account deduction. Please complete information below - we do not need a voided check.

- Routing Number: _____
- Checking Account Number: _____

☐ Auto Pay via Credit Card: Provide the card information below.

Card Type: ☐ Visa ☐ Mastercard ☐ Discover	Credit Card Number:
Expiration Date:	3-Digit Security Code:
Cardholder's Signature:	

If Auto-Pay is selected, I hereby authorize Willamette Dental of Idaho, Inc., to make reoccurring monthly withdrawals from the checking account / credit card listed for the then-current Dental Plus of Idaho premium amount. This authorization will remain in effect until I have provided notice to Willamette Dental of Idaho, Inc., and my bank with a reasonable amount of time to act upon the notice.

☐ Personal check, cashier's check, or money order: Enclose the first month's premium with this application payable to Willamette Dental of Idaho, Inc.

3 Applicant Enrollment Information

Self (Last, First, Middle Initial):	Social Security Number (*not required*):		
Requested Effective Date:	Gender:	DOB:	
Mailing Address:	City:	State:	Zip:
Home Phone:	Email Address:		

CONTINUE APPLICATION ON NEXT PAGE...

4 Dependent Enrollment Information

Legal Spouse or Domestic Partner (Last, First, Middle Initial):		
Social Security Number:	Gender:	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number:	Gender:	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number:	Gender:	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number:	Gender:	Date of Birth:

5 Producer of Record Information.

Please note: This section only applies to individuals applying with the help of an insurance agent. *Producers are required to have and maintain an Idaho producer license and appointment with Willamette Dental of Idaho, Inc.*

Producer Name: Karrin Archer		Agency Name: Archer Benefits	
Physical Address: 2879 Denise Avenue	City: Twin Falls	State: ID	Zip: 83301
Phone Number: 2088664825	Email Address: karrin@archerbenefits.com		

6 Acknowledgments and Signature

- I hereby apply for coverage under the Dental Plus of Idaho policy (Policy Form Number 001DPID(1/20)), which is a managed care dental policy underwritten by Willamette Dental of Idaho, Inc., 6950 NE Campus Way, Hillsboro, OR 97124, for myself and my listed dependents.
- I authorize providers of services to give Willamette Dental of Idaho, Inc., upon request, any information concerning the health, condition, or treatment of any person included under such coverage whenever such information is considered necessary for the proper administration of benefits in fulfillment of obligations imposed on Willamette Dental Insurance, Inc., by state or federal law.
- I understand if the application is declined and coverage is not issued, Willamette Dental of Idaho, Inc.'s only obligation will be to return any premium paid. If an incomplete application is received, a letter will be mailed to the applicant requesting the additional information. If the missing information is not received within two weeks, the application will be declined.
- I certify that all information supplied in this application form is true and complete to the best of my knowledge. I agree to advise Willamette Dental of Idaho, Inc., of any change in status within 31 days from the date of change.
- I understand that it may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
- If I choose to sign this application by typing my name below, I acknowledge and agree that my typewritten signature has the same legal effect as my written signature on this application.

Applicant's Signature _____ Date _____

Language Assistance Services

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-433-6825.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-433-6825。

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-433-6825.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-433-6825.

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-433-6825 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-433-6825.

Українська (Ukrainian)
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-433-6825.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-433-6825 まで、お電話にてご連絡ください。

Mon-Khmer, Cambodian
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-433-6825 ។

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-433-6825.

Oroomiffa (Oromo) (Cushite)
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-433-6825.

አማርኛ (Amharic)
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-433-6825.

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-433-6825 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-433-6825 .

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-433-6825 .

Contact Us

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

1.855.433.6825, Option 4

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

1.855.433.6825, Option 2

To schedule an appointment, please call:

1.855.433.6825, Option 1

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

willamettedental.com/dental-plus-of-idaho

Non-discrimination Statement

Willamette Dental Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Willamette Dental Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Willamette Dental Group:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact 1-855-433-6825.

If you believe that Willamette Dental Group has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Member Services Department, 6950 NE Campus Way Hillsboro, Oregon 97124
1-855-433-6825
Fax 503-952-2684
memberservices@willamettedental.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.