SUMMARY OF BENEFITS

Idaho Small Group Plans – 2024

Willamette Dental Group

COVERED BENEFITS	I58	I28	I78	I88
Annual Maximum	No Annual Maximum			
Deductible	No Deductible			
General or Orthodontic Office Visit	$15 per Visit	$15 per Visit	$20 per Visit	$20 per Visit
DIAGNOSTIC & PREVENTIVE SERVICES				
Routine & Emergency Exams	Covered with your Office Visit Copay			
X-rays	Covered with your Office Visit Copay			
Teeth Cleaning	Covered with your Office Visit Copay			
Fluoride Treatment	Covered with your Office Visit Copay			
Sealants (per Tooth)	Covered with your Office Visit Copay			
Head and Neck Cancer Screening	Covered with your Office Visit Copay			
Oral Hygiene Instruction	Covered with your Office Visit Copay			
Periodontal Charting and Evaluation	Covered with your Office Visit Copay			
RESTORATIVE DENTISTRY				
Fillings	Covered with the Office Visit Copay	$15	$15	$30
Porcelain-Metal Crown	$150	$200	$300	$325
PROSTHODONTICS				
Complete Upper or Lower Denture	$200	$200	$400	$450
Bridge (per Tooth)	$150	$200	$300	$325
ENDODONTICS & PERIODONTICS				
Root Canal Therapy - Anterior/Bicuspid/ Molar	$75/$100/$120	$75/$100/$125	$75/$100/$125	$150/$200/$250
Osseous Surgery (per Quadrant)	$150	$200	$250	$250
Root Planing (per Quadrant)	$50	$75	$85	$100
ORAL SURGERY				
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay	$15	$15	$30
Surgical Extraction	$80	$100	$125	$175
ORTHODONTIA TREATMENT				
Pre-Orthodontia Treatment	$150*	$150*	$150*	$150*
Comprehensive Orthodontia Treatment	$1,800	$2,200	$2,400	$2,500
MISCELLANEOUS				
Local Anesthesia	Covered with your Office Visit Copay			
Dental Lab Fees	Covered with your Office Visit Copay			
Nitrous Oxide	$40			
Specialty Office Visit	$30 per Visit			
Out of Area Emergency Care Reimbursement	$100			
2024 PREMIUM RATES				
Employee	$67.85	$62.60	$53.30	$39.95
Employee & Spouse	$135.80	$125.60	$106.85	$76.98
Employee & Child	$132.35	$122.30	$105.05	$76.11
Employee & Children	$162.95	$150.40	$128.20	$86.91
Employee & Family	$215.40	$198.85	$164.45	$121.82

*Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

Underwritten by Willamette Dental of Idaho, Inc.
Idaho small groups (5-50 eligible employees) are required to have a minimum of 5 enrollees regardless of group size. Presented are most common procedures covered by the plan. The certificate of coverage will contain a complete description of covered benefits and copays.

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EXCLUSIONS AND LIMITATIONS

Willamette Dental Group

This is only a summary. The certificate of coverage contains a complete description of the limitations and exclusions.

Exclusions

- 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, including attachment devices and maintenance.
- Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage.
- Endodontic therapy completed more than 60 days after termination of coverage.
- Exams or consultations needed solely in connection with a service that is not covered.
- Experimental or investigational services and related exams or consultations.
- Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.
- General anesthesia, moderate sedation and deep sedation.
- Hospital care or other care outside of a dental office for dental procedures, physician services, or facility fees.
- Maxillofacial prosthetic services.
- Nightguards.
- Orthognathic surgery.
- Personalized restorations.
- Plastic, reconstructive, or cosmetic surgery and other services which are primarily intended to improve, alter, or enhance appearance.
- Prescription and over-the-counter drugs and pre-medications.
- Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.
- Replacement of lost, missing, or stolen dental appliances. Replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
- Replacement of sound restorations.
- Services and related exams or consultations that are not within the prescribed treatment plan or are not recommended and approved by a Willamette Dental Group dentist.
- Services and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.
- 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, including an injury or disease arising out of self-employment or for which benefits are available under workers' compensation or similar law.
- Services for the treatment of injuries sustained while practicing for or competing in a professional athletic contest.
- Services for the treatment of intentionally self-inflicted injuries.
- Services for which coverage is available under any federal, state, or other governmental program, unless required by law.
- Services not included in the contract as covered.
- Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Limitations

- If alternative services can be used to treat a condition, the service recommended by the Willamette Dental Group dentist is covered.
- Services listed in the contract, which are provided to correct congenital anomalies will be covered for dependent children if dental necessity has been established.
- Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group dentist.
- The retreatment of root canal therapy performed by a Willamette Dental Group dentist will be covered as part of the initial treatment for the first 24 months. The retreatment of root canal therapy performed by a non-participating provider will be subject to the applicable copayments.
- The services provided by a dentist in a hospital must meet the requirements in the contract to be covered.
- The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance is covered if the appliance is more than 5 years old and replacement is dentally necessary.

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