Summary of Exclusions

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

Bridges, crowns, dentures or any 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, services, or supplies 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 or supplies. | Exams or consultations needed solely in connection with a service or supply not listed as covered. | Full mouth reconstruction. | General anesthesia, moderate 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. | Prescription and over-the-counter drugs and pre-medications. | Replacement of lost, missing, stolen or damaged dental appliances. | Replacement of sound restorations. | Services or supplies 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 or supplies by any person other than a licensed dentist, denturist, hygienist, or dental assistant. | Services or supplies for the diagnosis or treatment of temporomandibular joint disorders. | Services or supplies for the treatment of an occupational injury or disease. | Services or supplies for treatment of injuries sustained while practicing for or competing in a professional athletic contest of any kind. | Services or supplies for treatment of intentionally self-inflicted injuries. | Services or supplies for which coverage is available under any federal, state, or other governmental program. | Services or supplies that are not included in the appendices to the policy. | Services or supplies where there is no evidence of pathology, dysfunction, or disease.

Dental Plus of Idaho

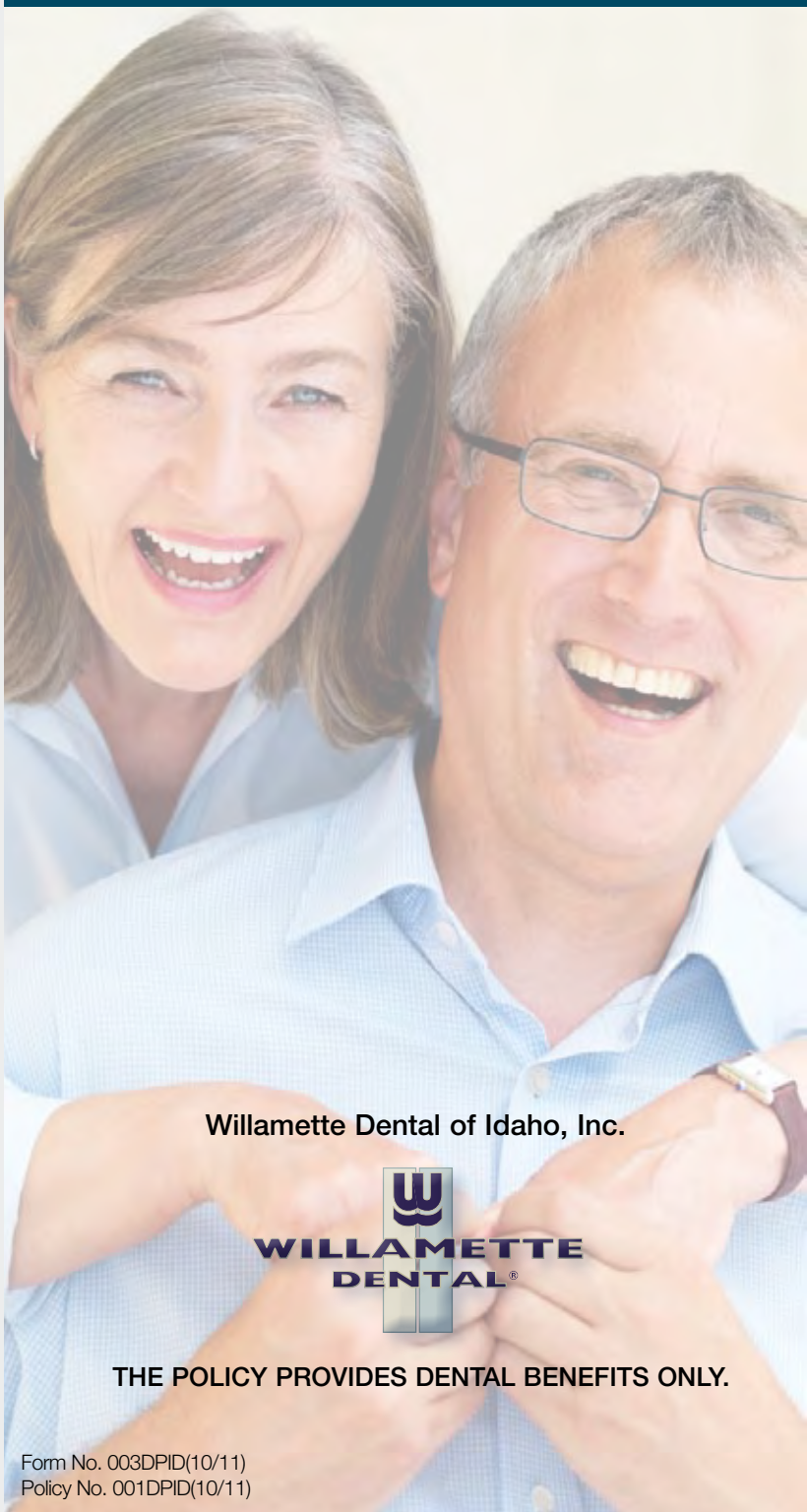
For Billing and Eligibility Questions, please call:
855-289-6318

For Customer Service, please call:
866-851-8314

The Dental Plus of Idaho plan is underwritten by
Willamette Dental of Idaho, Inc.
6950 NE Campus Way, Hillsboro, OR 97124

www.WillametteDental.com

Willamette Dental
Dental Plus
of Idaho



Willamette Dental of Idaho, Inc.

WILLAMETTE DENTAL®

THE POLICY PROVIDES DENTAL BENEFITS ONLY.

Form No. 003DPID(10/11)
Policy No. 001DPID(10/11)

Willamette Dental
Dental Plus
of Idaho

Affordable Quality Dental Care

- No Annual Maximums
- No Deductibles
- No Claim Forms
- Low Copayments on Preventative Services
- Orthodontia Coverage

Dental Offices

With more than 50 dental office locations conveniently located throughout Idaho, Washington, and Oregon there is probably a Willamette Dental Office near your work or home.

Idaho Locations

Boise
8950 W. Emerald St
Suite 108
Boise, ID 83704

Meridian
Midvalley Prof. Bldg.
2365 Gala St
Suite 1
Meridian, ID 83642

Coeur d'Alene
943 W. Ironwood Dr.
Coeur d'Alene, ID
83814

Idaho Falls
2860 Valencia Dr.
Suite 100
Idaho Falls, ID 83404

Eastern Washington
Pullman
Spokane - Northpointe
Spokane - South Hill

WILLAMETTE DENTAL®

www.WillametteDental.com
To Find A Dental Office Near You

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, nor are there any deductibles that need to be met. Your coverage gives you simple access to dental care. Routine and preventive services are covered with low copayments. Major services, such as crowns, bridges, and dentures are covered following a six-month waiting period at substantial savings with predictable costs.

Coverage for orthodontic treatment is available to both adults and children after a six-month waiting period. Plan participants do not need to fill out or submit claim forms. As a plan enrollee, you simply schedule your appointments, see the dentist and pay copayments at that visit. Willamette Dental Group, P.C., dentists make access to quality dental care easy, while the Dental Plus of Idaho plan keeps that care affordable for you and your family.

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 (800) 603-1738. When you speak to a Willamette Dental 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 plan.

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

Premium Rates

	Monthly	Quarterly	Semi-Annual	Annual
Member Only	$37.36	$112.08	$224.16	$448.32
Member & Spouse or Domestic Partner	$73.30	$219.90	$439.80	$879.60
Member & Children	$70.31	$210.93	$421.86	$843.72
Family	$130.21	$390.63	$781.26	$1562.52

You may pay premiums on a monthly, quarterly, semi-annual or annual basis. Payment may be made by personal check or if paying monthly an automatic electronic funds transfer (EFT). There is a $5 paper billling statement fee if paying by personal check. There is no additional fee if paying by EFT. No credit card payments will be accepted.

Benefit Summary

For services by a Participating Dentist

Benefit	Copayment
Annual Maximum	No Annual Maximum
Deductible	No Deductible
General Office Visit	$0
Specialist Office Visit	$0
Emergency Office Visit	$0
Dental Exams	$20
X-rays	$20
Teeth Cleaning (adult)	$50
Fluoride Treatment (adult)	$25
Sealants per Tooth	$30
Filling - Amalgam	$50
Filling - Resin (Anterior & Posterior Primary)	$50
Filling - Resin (Posterior Permanent)	$102
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 2]	$3,000
Nitrous Oxide per Visit	$20
Out of area emergency treatment and other services from a Non-Participating Provider are reimbursed up to $10.[3]	

1 Benefit available after a six-month waiting period.

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

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

www.WillametteDental.com

Agreement

I hereby apply for coverage under the Willamette Dental Dental Plus of Idaho plan underwritten by Willamette Dental of Idaho, Inc. for myself and for 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 of Idaho, Inc. by state or federal law.

I understand the policy effective date will be the first day of the month if premium payment and application are received by the 25th of the previous month; and 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 terminated/voided.

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. Limited to two years within filing this form, I understand that my membership may be null and void if I have provided any information which is false or misleading regarding myself or my dependents on this form or any form filed in conjunction with this plan.

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, and that penalties may include imprisonment, fines and denial of insurance benefits.

Applicant's signature: _____

Date: _____

Mail this completed application and your premium payment to:

Willamette Dental of Idaho, Inc.
Willamette Dental Dental Plus of Idaho
601 SW Second Avenue
Portland, OR 97204-3156

Make checks payable to: **Willamette Dental of Idaho, Inc.**

How to Enroll

To enroll in the Dental Plus of Idaho plan, simply complete the application form and submit it along with premium payment. The application and premium payment must be received by the 25th of the month preceding the period for which coverage is to be effective.

You must be at least 18 years of age and a resident of Idaho. Your eligible dependents include your spouse or domestic partner and you or your spouse or domestic partner's children through age 25.

If you would like additional information, please contact us at dpi@willamettedental.com.

IDAHO

Willamette Dental of Idaho, Inc.

Willamette Dental
Dental Plus
of Idaho

Willamette Dental Dental Plus of Idaho Application Form

Please print or type • Shaded areas are for producer or office use only

Account Number:	Effective Date:

Name of Applicant: Last, First, Middle Initial

Mailing Address: City: State: Idaho Zip:

Home Phone: Social Security Number:

Date of Birth: M/F:

Requested Effective Date: Email Address:

Premium Payment Frequency (check one): ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Premium Payment Method (check one): ☐ Personal Check ☐ Monthly EFT (Please complete information below)

I am applying for coverage for: ☐ Member Only
☐ Member & the Dependents listed below

Checking Account Number: _____

Routing Number: _____

List All Persons Below That You Wish to Enroll

Spouse or Domestic Partner Name: (Full Name)	Date of Birth: Social Security Number:	M/F:
Child Name: (Full Name)	Date of Birth: Social Security Number:	M/F:
Child Name: (Full Name)	Date of Birth: Social Security Number:	M/F:
Child Name: (Full Name)	Date of Birth: Social Security Number:	M/F:

Pay Commissions To: ☐ Producer ☑ Agency	Producer SSN or Agency Tax ID: 20-320724
Producer or Agency Name: Insurers of Idaho	Phone: 208-344-3388
Producer or Agency Address: 5660 E. Franklin Rd. Suite #300, Nampa, ID 83687	
Producer or Agency State License Number: 134107	Producer or Agency Appointment Eff Date: 4/16/2009