DELTA DENTAL

Delta Dental	
Employee Type	**Amt/Month**
Employee Only (EE)	$42.53
Employee + Spouse (ES)	$85.12
Employee + One Child (EC1)	$80.31
Employee + Two Children (EC2)	$99.95
Employee + Children (EC3)	$99.95
Employee + Family (EF)	$139.64

Benefit Summary

GENERAL BENEFIT PLAN SUMMARY

AgriSource, Inc.
Group Number: 2827
Contract Effective Date: 07/01/2024

Benefit Overview	PPO	Premier	Non-Participating
Per Person Deductible Excluding Diagnostic and Preventive services per benefit year	$50	$50	$50
Family Deductible Excluding Diagnostic and Preventive services per benefit year	$150	$150	$150
Maximum Benefit Per eligible person per benefit year	$1,250	$1,000	$1,000

Services	You pay the % below		
Preventive & Diagnostic Services Examinations, X-rays, teeth cleaning	0%	20%	20%
Basic Services Fillings, root canals, extractions, oral surgery	20%	30%	30%
Major Services Crowns, implants, onlays, bridges, dentures Late enrollee waiting period is 12 months	50%	60%	60%

PARTICIPATING AND NON-PARTICIPATING DENTISTS

If the dentist is a network participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee. Delta Dental will send payment to the participating dentist and the subscriber will be responsible for any co-payment and/or any non-covered services.

If the dentist is a non-participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or Delta Dental's non-participating dentist Fee. It is the subscriber's responsibility to make full payment to the non-participating Dentist. For dental services rendered by an out-of-state dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee in that area, if the out-of-state dentist is a participating dentist with a Delta Dental plan in the state in which the service is rendered.

Looking for a Dentist? Find a dentist by visiting: https://www.deltadental.com/us/en/member/find-a-dentist.html

Delta Dental of Idaho
555 E Parkcenter Blvd
Boise, ID 83706

Customer Service
(208) 489-3580
(800) 356-7586

Benefits and Limitations

Class I Preventive and Diagnostic Services
Periodic exam is allowed 2 times every calendar year.
Single bitewing x-ray is allowed 1 time every 12 months from last date of service.
Full mouth series or panoramic x-rays are allowed 1 time every 5 years from last date of service .
Adult and child cleanings are allowed 2 times every calendar year (restricts against periodontal maintenance within the same time period).
Fluoride treatment is allowed 2 times every 1 year from last date of service through age 18.
Class II Basic Services
Fillings restricted to same tooth/surface are allowed 1 time every 24 months .
Periodontal surgeries per quadrant are allowed 1 time every 3 years from last date of service .
Periodontal scaling and root planing-per quadrant is allowed 1 time every 24 months from last date of service.
Periodontal maintenance procedure is allowed 4 times every 12 months (if patient has had previously treated periodontal disease).
Class III Major Restorative Services
Porcelain, porcelain substrate, and cast restorations are not payable for children less than 12 years of age.
Crowns, stainless steel crowns, onlays, or bridges on same tooth are allowed 1 time every 7 years from last date of service .
Partials or dentures per arch are allowed 1 time every 7 years from last date of service for ages 16 and older.
Implants
Implants are a covered benefit per tooth with a maximum lifetime benefit of $1,200 or the plan's annual maximum, whichever is less. Ages 19 and over.
Dependents
Eligible children must be under age 26.

GENERAL PLAN INFORMATION

1. Optional treatment: If the subscriber or eligible dependent selects a more expensive service than is customarily provided. For example, if teeth can be restored satisfactorily with amalgam or composite material, the cost of inlays, onlays and crowns are not covered and the cost difference between the covered and the non-covered procedure is to be borne by the patient.
2. Payment provisions: The following guidelines will be used to determine the date on which a service shall be paid:
    a. Full dentures or partial dentures: On the date the final impression is taken.

b. Fixed bridges, crowns, and onlays: On the date the tooth or teeth are prepared.

c. Root canal therapy: On the date the root canal is initiated.

3. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of Benefits (EOB).

4. Predeterminations: If your dental treatment involves services of $300 or greater, it is advisable to ask your dentist to submit a predetermination of benefits. A statement will be sent to you and your dentist estimating the amount of Delta Dental payment obligation and the amount that you will owe. These estimates will be subject to your continuing eligibility in the plan and the group contract remaining in effect. If claims for other completed dental services are received and processed prior to the completion date of the proposed treatment, this may reduce Delta Dental's estimated payment for the proposed treatment and increase your obligation to the dentist. Predeterminations are valid for ninety (90) days from the date issued by Delta Dental.

WHAT SERVICES ARE NOT COVERED?

No payment will be made by Delta Dental and all charges for the following services will be the responsibility of the subscriber:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Benefits or services that are available from any government agency, political subdivision, community agency, foundation, or similar entity. This provision does not apply to any programs provided under Title XIX Social Security Act, i.e., Medicaid.
2. Service for cosmetic surgery, or dentistry for aesthetic reasons, unless specified otherwise in Benefits and Limitations section above.
3. Services or appliances started before an individual became eligible under the contract.
4. Prescription drugs, pre-medications and/or relative analgesia. General anesthesia and/or intravenous sedation other than for covered oral surgery. Charges for hospitalization, laboratory tests, and examinations and any additional fees charged by the dentist for hospital treatment.
5. Preventive control programs, including home care items.
6. Charges for failure to keep a scheduled visit with the dentist.
7. Repair, relines, or adjustments of occlusal guards.
8. Charges for completion of forms. A participating dentist may not make these charges to a subscriber or eligible dependent.
9. Prosthodontic services (Class III benefits), unless specified as a covered service in the Benefit Summary.
10. Orthodontic services (Class IV benefits), unless specified as a covered service in the Benefit Summary.
11. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances.
12. Services for which no valid dental need can be demonstrated, that are specialized techniques, or that are experimental in nature as determined by the standards of generally accepted dental practice.
13. Appliances, surgical procedures, and restorations for increasing vertical dimension; for restoring occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion. If orthodontic benefits have been selected under this contract, this exclusion will not apply to the orthodontic services.
14. Treatment by other than a dentist, except for services performed by a licensed dental hygienist or denturist within the scope of his or her license.
15. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of Benefits (EOB).
16. Services or supplies for which no charge is made, or for which the patient is not legally obligated to pay. This includes services or supplies furnished by a dentist who is related to the patient by blood or who is related to the patient by blood or marriage and who ordinarily dwells in the patient's household, the dentist providing service to him/her self, or services which would not have a charge in the absence of Delta Dental coverage.

17. Services or supplies received as a result of defect, or injury due to an act of war, declared or undeclared.
18. Services that are covered under a hospital, surgical/medical, or prescription drug program.
19. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
20. Myofunctional therapy.
21. Delta Dental is not obligated to pay claims received more than 12 months after the date of service.
22. Nutritional counseling, tobacco counseling and oral hygiene instruction are not covered benefits except for participants in Delta Dental's Health through Oral Wellness® (HOW®) program.

This is only a general summary of benefits. It provides a brief description about the important features of this policy and does not constitute a contract or guarantee of payment. Full terms and conditions are set forth in the policy provisions. If you have any questions about your plan's benefits or would like to submit a predetermination before services are performed, please call Delta Dental of Idaho customer service advisors at (208) 489-3580 or toll-free at (800) 356-7586. You may also log onto our website, www.deltadentalid.com, for benefit and eligibility information or up-to-date claim status.

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