



VOLUNTARY DENTAL BENEFITS OUTLINE		
Visit our Web site at www.bcidaho.com to locate a Contracting Provider		
Deductibles (Per Benefit Period)	In-Network	Out-of-Network
(Deductible applies to In-Network basic and major services	The Insured is responsible to pay these amounts:	
and all Out-of-Network services.)		
Individual	\$25	\$50
Family (No Insured may contribute more than the Individual Deductible amount toward the Family Deductible)	The Benefit Period Family Deductible is satisfied after three (3) Insureds of the same family have met their Individual Deductible	The Benefit Period Family Deductible is satisfied after three (3) Insureds of the same family have met their Individual Deductible
Benefit Period Limit	<b>\$1,000</b> per Insured	
Preventive Dental Services (No Waiting Period)	\$20 Copayment per visit (Deductible does not apply)	30% of Maximum Allowance after Deductible
Basic Dental Services (Six (6) month Waiting Period)	20% of Maximum Allowance after Deductible	50% of Maximum Allowance after Deductible
Major Dental Services (Twelve (12) month Waiting Period)	50% of Maximum Allowance after Deductible	60% of Maximum Allowance after Deductible
Orthodontia Lifetime Limit (Twenty-four (24) month Waiting Period)	Ortho Not Covered	
Orthodontic Services Select	Ortho Not Covered	Ortho Not Covered