Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

Form No. VolDent (01/24)

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding contract/policy, which contains all the terms and conditions of coverage and exclusions and limitations. Certain services not specifically noted may be excluded. Please refer to the contract/policy issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding contract/policy, the contract/policy will control.

CS1B Vol Den Plan A w/o ortho

VOLUNTARY DENTAL
BENEFITS OUTLINE
Visit our Website at www.bcidaho.com to locate a Contracting Provider

Deductibles (Per Benefit Period) *(Deductible applies to In-Network basic and major services and all Out-of-Network services.)*	**In-Network**	**Out-of-Network**
	The Insured is responsible to pay these amounts:	
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	$1,000 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