Mountain West Dental Care

PEAK MEMBERSHIP PLAN

👤 **1 Person** 2 Adult Prophylaxis Cleanings per year $25
- $275 if paid in full

👥 **2 People** 2 Adult Prophylaxis Cleanings (per person/year) $45
- $495 if paid in full

👤 **1 Person** 2 Periodontal Maintenance Visits per year $35
- $385 if paid in full

👥 **2 People** 2 Periodontal Maintenance Visits (per person/year)$55
- $605 if paid in full

👤 **1 Person** 4 Periodontal Maintenance Visits per year $50
- $550 if paid in full

👥 **2 People** 4 Periodontal Maintenance Visits (per person/year)$90
- $990 if paid in full

👤Additional Dependents
Under Age 26: +$15/month per dependent

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Mountain West Dental Care Peak Plan is a reduced-fee dental membership plan that allows individuals and families to receive quality dental services from Mountain West Dental Care dentists at reduced prices. You, your spouse, dependent children up to 26 years of age, and children over 26 with a developmental disability or physical handicap are eligible. Individuals under the age of 18 may only be members as the dependents of adults.

The discount program is NOT a health insurance policy and does not make payments directly to dental service providers. Members are obligated to pay for all dental services but may receive discounts on dental services from participating providers and the discount range may vary. The program does not meet the minimum creditable coverage requirements under any law and is not a Qualified Health Plan under the Affordable Care Act. If you cancel within the first 30 days after activation you will receive a full refund, except for the enrollment fee of $12 where permitted by law.
Program administered by Mountain West Dental Care Peak Plan, LLC, 675 S. Woodruff Ave., Idaho Falls, ID 83401 (208) 538-0104. Email us at peakplan@mountainwestdentalcare.com. Website: www.mountainwestdentalcare.com. Members who cancel after receiving benefits may be liable for the difference between the Peak Plan fee and the provider's normal and customary fee for treatment, payable to the provider.

Members may add additional family members by providing a written request and paying any additional membership fees. Changes will be effective 30 days from the receipt of written requests. Complaints about the Peak Plan should be addressed to: Mountain West Dental Care Peak Plan, 675 S. Woodruff Ave., Idaho Falls, ID 83401. Complaints will be addressed within 30 days of receipt. If a member remains dissatisfied, he or she may contact his or her state's insurance department. The Peak Plan does not guarantee the quality of services or products offered by individual providers.

Peak Plan Membership provides you with local anesthetics, examinations, x-rays, and other preventive services at NO CHARGE plus reduced fees on most other dental services. The complete Reduced Fee Schedule can be viewed at www.mountainwestdentalcare.com for full details on discounted services.

This contract is not protected by any state guaranty fund. The program and program administrator is not liable for providing or guaranteeing health services or for the quality of health services rendered. Membership and activation fees apply. The Peak Plan is governed by this Membership Agreement. Participating providers are not available in all areas and are subject to change without notice. Program is not available in all states. To join fill our online form at www.mountainwestdentalcare.com or fill out the paper form.
You have Three methods of payments:
1. YEARLY:
One lump sum payment by check or credit card.
2. MONTHLY BY CREDIT/DEBIT CARD.
Enclose valid credit/debit card number with expiration date and name of cardholder plus 3 or 4 digit code. Your card will be charged the first month, last month and enrollment fee to enroll. Remaining monthly payments will be automatically charged to the same card on the first of each month.
3. MONTHLY BY CHECKING ACCOUNT DEBIT.
(for paper forms) Enclose a check for the first and last month's payment. Also include a voided check. Remaining payments will be deducted from your checking account on the first of each month. Members choosing to pay in this way will be automatically renewed. A written request is required for cancellation.

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DENTAL LIMITATIONS AND EXCLUSIONS

1. **Services that, in the opinion of the attending dentist, are neither necessary nor recommended for the patient's dental health.**
2. **Restorations, splints, or other appliances used to increase vertical dimension or restore occlusion.**
3. **Oral surgery requiring the setting of fractures or dislocations.**
4. **Treatment of malignant cysts, neoplasms, or congenital malformations, except teeth that are congenitally missing or congenitally malformed, which are covered for replacement and/or restoration.**
5. **Dispensing of drugs not normally supplied in a dental office.**
6. **Hospital benefits for any dental procedures.**
7. **Loss or theft of dentures or bridgework.**
8. **Any experimental procedures.**
9. **Services for injuries or conditions that are covered under Workers' Compensation or Employer Liability laws.**
10. **Services that are provided without cost to the member by any municipality, county, or other political subdivision.**
11. **Services that cannot be performed because of the general health, physical, or psychological limitations of the patient.**
12. **Periodontics, endodontics, oral surgery, or pedodontics requiring the services of a non-participating dentist.**
13. **General anesthesia.**
14. **Procedures requiring appliances or restorations necessary for full-mouth rehabilitation, or to alter, restore, or maintain occlusion, including, without limitation, treatment of temporomandibular joint (TMJ) disorders.**
15. **Diagnosis and treatment of myofascial pain dysfunction syndrome.**
16. **Procedures performed in a hospital setting.**
17. **Peak Plan discounts cannot be used in conjunction with other dental discount plans.**
18. **Demonstrated non-compliance with a recommended course of treatment may result in membership cancellation.**

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PEAK MEMBERSHIP PLAN

MEMBER INFORMATION

Last Name: _____ **First Name:** _____

MI: _____ **Birth Date:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Preferred Contact Method: □ Mail □ Phone □ Email

ELIGIBLE DEPENDENTS

Name Birth Date Relationship

Mountain West Dental Care

PEAK MEMBERSHIP PLAN

PAYMENT METHOD (Circle One)

□ Yearly □ Monthly

Monthly bank draft (1st & last month's payment charged). Include voided check if using bank draft.

CREDIT CARD AUTHORIZATION

Card #: _____

Exp: _____ CVV: _____

3 digits on back of card or 4 digits on front of AmEx.

If paying monthly by charge card, the first and last month's payment will be charged to this account on the first of each month.

12-month annual payment included if paid in full.

MEMBERSHIP AGREEMENT

I understand the benefits, limitations, exclusions, and requirements of the plan and agree to remain in the plan and pay membership fees for 12 months.

Where permitted by law, payment of less than 12 months' membership fees may result in my being charged usual and customary fees for all services (including those already provided) and remaining membership fees in a lump sum.

Fees for dental services are due as services are rendered. Fees for prosthodontic and cast restoration services are due at the preparation/impression visit.

Failure to comply may result in usual and customary fees being charged. I agree to pay all collection costs, including attorney fees and court costs.

Membership must be continuous. Missed monthly payments must be made up for interrupted membership.

Signature: _____

Date: _____

TERMS AND CONDITIONS OF AUTHORIZATION TO HONOR DEBITS

For a complete list of terms, conditions, and exclusions visit:
mountainwestdentalcare.com/PeakPlan

The member enrolling in the Peak Plan authorizes their bank to pay and charge to their account checks drawn by and payable to Mountain West Dental Care Peak Membership Plan, provided sufficient funds are available.

This authorization remains in effect until revoked in writing. The member agrees the bank is fully protected in paying such checks and shall not be liable if a payment is dishonored, even if membership is suspended as a result.

The member agrees to indemnify and hold harmless both the bank and Mountain West Dental Care Peak Membership Plan from losses, costs, expenses, or actions arising from the execution, collection, or dishonor of such payments.

Payments will be withdrawn on the first day of each month. During renewal months, the first and last month's payment may be charged.

ACH AUTHORIZATION

Bank Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____
□ Checking □ Savings
Account #: _____
Routing #: _____

Please include a voided check from account to be drafted

I authorize Mountain West Dental Care Peak Membership Plan to draft my account and agree to maintain membership for a minimum of one year. Less than one year of membership may result in usual and customary fees being charged. Cancellation of bank drafting must be submitted in writing 30 days prior to the end of the 12-month term.

Signature: _____
Date: _____

Mail Form To:
Mountain West Dental Care Peak Membership Plan
675 S Woodruff Ave.
Idaho Falls, ID 83401

Mountain West Dental Care

PEAK MEMBERSHIP PLAN

ADA Code	UCR	Member
Preventative and Diagnostic		
D0150 Inital Oral Exam	$102	**N/C**
D0120 Periodic Oral Exam	$58	**N/C**
D0140 Emergency Oral Exam (2/year)	$150	**N/C**
D0210 Complete Series X-Rays (every 3 yrs)	$153	**N/C**
D0274 Four bitewing X-Rays (1 every year)	$73	**N/C**
D1208 Fluoride Treatment (2/year)	$45	**N/C**
D1351 (Pit & Fissure) per tooth	$55	**$30**
D9986 Missed/ Canceled appointments	$77	**$50**
Anterior Resin Restorations (Front tooth fillings)		
D2330 One Surface	$177	**$125**
D2331 Two Surfaces	$212	**$149**
D2332 Three Surfaces	$257	**$180**
D2335 Four or more surfaces	$316	**$200**
Posterior Resin Restorations (Back tooth fillings)		
D2391 One Surface	$189	**$135**
D2392 Two Surfaces	$243	**$170**
D2393 Three or more surfaces	$310	**$220**
Crown and Bridge		
D2740 Porcelain/ Zirconia Crown	$1100	**$860**
D2910 Recement crown	$142	**$55**
D2950 Crown build-up including any pins	$245	**$130**
D2954 Pre-fab post and core	$379	**$150**
D2962 Cosmetic Porcelain/ Zirconia Veneer	$1435	**$1000**
D6058 Implant Crown	$1500	**$1200**
D6740 Porcelain/ Zirconia Retainer Crown	$1150	**$805**
D6245 Porcelain/ Zirconia Pontic Crown	$1100	**$860**
D6930 Recement Bridge	$189	**$133**

ADA Code	UCR	Member
Oral Surgery		
D7140 Routine Extraction	$175	**$123**
D7210 Complex Extaction	$275	**$193**
D7220 Soft Tissue Extraction	$311	**$218**
D7230 Partial Bony Impaction	$422	**$296**
D7240 Complete Bony Impaction	$475	**$333**
D7310 Alveoplasty/ Quad with Extractions	$355	**$249**
D7320 Alveoplasty / Quad w/out Extractions	$512	**$359**
Implants		
D6010 Implant	$1600	**$1250**
D6056 Implant abutment- Prefabricated	$790	**$553**
D6057 Implant abutment- Custom	$750	**$525**
D6058 Implant Crown	$1500	**$1200**
Endodontics (root canals)		
D3220 Therapeutic Pulpotomy	$233	**$180**
D3221 Pupal Debridement	$257	**$190**
D3310 RCT Anterior	$750	**$525**
D3320 RCT Bicuspid	$860	**$602**
D3330 RCT Molar 3 Canals	$1000	**$850**
D3340 RCT Molar 4 Canals	$1250	**$1000**
Periodontics (gum treatment)		
D4341 Scaling/ Root Planning 1-3 teeth/ quad	$275	**$148**
D4342 Scaling/ Root Planning 4+ teeth/ quad	$311	**$200**
Other Services		
D9230 Nitrous Oxide (60 min session)	$99	**$60**
D9244 Oral Conscious Sedation	$175	**$40**
D9239 IV Moderate Sedation first 15	$197	**$50**
D9243 IV moderate Sedation each 15 min	$168	**$50**