Summary of Exclusions

Please refer to your policy for a complete description of co-payments, 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, including conscious, intravenous and 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 listed as covered in the policy. | Services or supplies where there is no evidence of pathology, dysfunction, or disease.

Willamette Dental TrueCare Washington

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

For Customer Service, please call:
855-99TCARE (998-2273)

The Willamette Dental TrueCare Washington plan is underwritten by

Willamette Dental of Washington, Inc.
6950 NE Campus Way, Hillsboro, OR 97124

www.WillametteDental.com

Willamette Dental TrueCare Washington

Willamette Dental of Washington, Inc.

THE POLICY PROVIDES DENTAL BENEFITS ONLY.

Form No. 003IWA(4/11)
Policy No. 001I-WA(3/11)

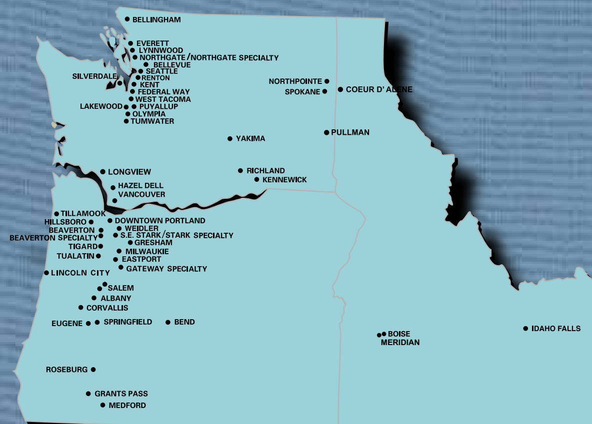
Willamette Dental
TrueCare
Washington

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 Washington, Oregon, and Idaho there is probably a Willamette Dental Office near your work or home.



Washington Locations

Bellevue	Bellingham
Everett	Federal Way
Kennewick	Kent
Lakewood	Longview
Lynnwood	Olympia
Pullman	Puyallup
Renton	Richland
Seattle - Dexter	Seattle - Northgate
Silverdale	Spokane - Northpointe
Spokane - South Hill	Tumwater
Vancouver - Hazel Dell	Vancouver - Mill Plain
West Tacoma	Yakima

<u>Specialty Office</u>
Northgate Specialty

<u>Northern Idaho</u>
Coeur d'Alene

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

Benefit Summary

Willamette Dental of Washington, Inc., is pleased to offer you Willamette Dental TrueCare Washington. 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 Willamette Dental TrueCare Washington 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) 359-6019. When you speak to a Willamette Dental representative or arrive at the dental office for your appointment, simply identify yourself as a Willamette Dental TrueCare Washington 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.

Benefit	Copayment
Annual Maximum	No Annual Maximum
Deductible	No Deductible
General Office Visit	$25
Specialist Office Visit	$30
Emergency Office Visit	$50
Dental Exams and X-rays	$0
Teeth Cleaning	$0
Fluoride Treatment	$15
Sealants per Tooth	$15
Filling - Amalgam	$25
Filling - Resin (Anterior & Posterior Primary)	$50
Filling - Resin (Posterior Permanent)	$102
Stainless Steel Crown	$70
Porcelain Fused to Metal Crown[1]	$400
Complete Denture[1]	$500
Bridge (per tooth)[1]	$400
Root Canal Therapy – Anterior Tooth	$200
– Bicuspid Tooth	$225
– Molar	$250
Osseous Surgery Per Quadrant	$300
Root Planing Per Quadrant	$75
Routine Extraction	$50
Surgical Extraction	$100
Pre-Orthodontic Service[1,2]	$150
Comprehensive Orthodontia[1,2]	$2,800
Nitrous Oxide Per Visit	$40
Out of area emergency treatment is reimbursed up to $100 minus applicable copayments.	

1 Benefit available after a six month waiting period.

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

How to Enroll

To enroll in the Willamette Dental TrueCare Washington 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 Washington. 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 tcw@willamettedental.com

www.WillametteDental.com

Agreement

I hereby apply for coverage under the Willamette Dental TrueCare Washington plan underwritten by Willamette Dental of Washington, Inc. for myself and for my listed dependents.

I authorize providers of services to give Willamette Dental of Washington, 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 Washington, 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 Washington, 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 Washington, 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 is 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 is a crime to knowingly provide false, incomplete, or misleading information to an insurance company or health care service contractor for the purpose of defrauding the company, and that penalties include imprisonment, fines and denial of insurance benefits.

Applicant's signature: ______________________________

Date: _______________

Mail this completed application and your premium payment to:

Willamette Dental of Washington, Inc.
Willamette Dental TrueCare Washington
601 SW Second Avenue
Portland, OR 97204-3156

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

Premium Rates

You may pay premiums on a monthly, quarterly, semi-annual or annual basis. Payment may be made by personal check or an automatic electronic funds transfer (EFT). No credit card payments will be accepted.

Premium Rates for Payments by EFT

	Monthly	Quarterly
Member Only	$35	$105
Member and Spouse Only	$70	$210
Member and Children Only	$63	$189
Member, Spouse, and Children	$98	$294

	Semi Annually	Annually
Member Only	$210	$420
Member and Spouse Only	$420	$840
Member and Children Only	$378	$756
Member, Spouse, and Children	$588	$1,176

Premium Rates for Payments by Personal Check

	Monthly	Quarterly
Member Only	$40	$110
Member and Spouse Only	$75	$215
Member and Children Only	$68	$194
Member, Spouse, and Children	$103	$299

	Semi Annually	Annually
Member Only	$215	$425
Member and Spouse Only	$425	$845
Member and Children Only	$383	$761
Member, Spouse, and Children	$593	$1,181

WASHINGTON

Willamette Dental of Washington, Inc.

Willamette Dental
TrueCare
Washington

Willamette Dental TrueCare Washington 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: Washington Zip:
Home Phone:	Social Security Number:
Date of Birth:	M/F:
Requested Effective Date:	Email Address:

Premium Payment Method & Frequency (select one):

o Monthly by Personal Check

Member Only	$40
Member and Spouse Only	$75
Member and Children Only	$68
Member, Spouse, and Children	$103

o Quarterly by Personal Check

Member Only	$110
Member and Spouse Only	$215
Member and Children Only	$194
Member, Spouse, and Children	$299

o Semi-Annually by Personal Check

Member Only	$215
Member and Spouse Only	$425
Member and Children Only	$383
Member, Spouse, and Children	$593

o Annually by Personal Check

Member Only	$425
Member and Spouse Only	$845
Member and Children Only	$761
Member, Spouse, and Children	$1,181

o Monthly by Electronic Funds Transfer

Member Only	$35
Member and Spouse Only	$70
Member and Children Only	$63
Member, Spouse, and Children	$98

o Quarterly by Electronic Funds Transfer

Member Only	$105
Member and Spouse Only	$210
Member and Children Only	$189
Member, Spouse, and Children	$294

o Semi-Annually by Electronic Funds Transfer

Member Only	$210
Member and Spouse Only	$420
Member and Children Only	$378
Member, Spouse, and Children	$588

o Annually by Electronic Funds Transfer

Member Only	$420
Member and Spouse Only	$840
Member and Children Only	$756
Member, Spouse, and Children	$1,176

Checking Account Number:____________________ Routing Number: ____________________

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

List all dependents below that you wish to enroll.

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

Pay Commissions To: ❑ Producer ❑ Agency	Producer SSN or Agency Tax ID:
Producer or Agency Name:	Phone:
Producer or Agency Address:	
Producer or Agency State License Number:	Producer or Agency Appointment Eff Date: