



TRUECARE IDAHO

The TrueCare Idaho plan is a managed care dental policy and is underwritten by:
Willamette Dental of Idaho, Inc.
6950 NE Campus Way, Hillsboro, OR 97124
For Policy 001TRUE-ID(1/21)
THE POLICY PROVIDES DENTAL BENEFITS ONLY.

005TRUEID(1/21)


Willamette
Dental Group

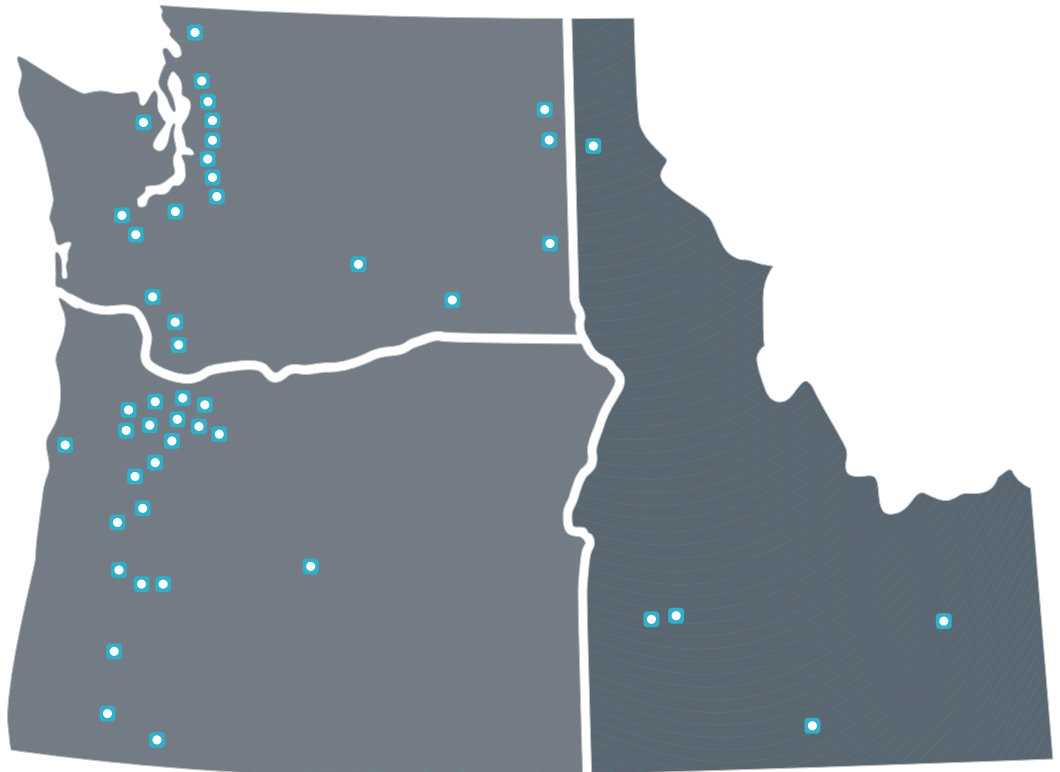
PERSONAL CARE

FOR YOUR INDIVIDUAL NEEDS

Willamette Dental of Idaho, Inc. is pleased to offer you **TrueCare Idaho**. 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 and there are no deductibles that need to be met. Your coverage gives you simple access to dental care.

IDAHO AND EASTERN WASHINGTON LOCATIONS

- Boise
- Coeur d'Alene
- Idaho Falls
- Meridian
- Pullman
- Spokane - Northpointe
- Spokane Valley
- Twin Falls



To receive benefits, you should 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 1.855.433.6825, Option 1. When you speak to a Willamette Dental Group representative or arrive at the dental office for your appointment, simply identify yourself as a TrueCare Idaho member. You will then receive dental care in accordance with your policy.

Most dental offices are open Monday through Friday, 7 AM to 6 PM, and occasional Saturdays.

BENEFIT SUMMARY FOR SERVICES BY A PARTICIPATING DENTIST

COVERED SERVICES	MEMBER BENEFITS
Annual Maximum	No Annual Maximum
Deductible	No Deductible
General Office Visit	\$25 Copay
Specialist Office Visit	\$35 Copay
Dental Exams and X-rays	\$0 Copay
Teeth Cleaning	\$0 Copay
Fluoride Treatment	\$15 Copay
Sealants per Tooth	\$15 Copay
Filling - Amalgam	\$45 Copay
Filling - Resin (Anterior)	\$70 Copay
Filling - Resin (Posterior)	\$80 Copay
Stainless Steel Crown	\$90 Copay
Porcelain/Metal Crown	\$500 Copay ¹
Complete Upper or Lower Denture	\$600 Copay ¹
Bridge (per Tooth)	\$500 Copay ¹
Root Canal Therapy - Anterior Tooth / Bicuspid Tooth / Molar	\$225 / \$325 / \$425 Copays
Osseous Surgery (per Quadrant)	\$325 Copay
Root Planing (per Quadrant)	\$100 Copay
Routine Extraction (per Tooth)	\$50 Copay
Surgical Extraction (per Tooth)	\$190 Copay
Pre-Orthodontic Services	\$150 Copay ^{1,2}
Comprehensive Orthodontia	\$2,800 Copay ¹
Nitrous Oxide Per Visit	\$50 Copay

Out of area emergency treatment by an out-of-network provider is reimbursed at \$100 per visit. This plan covers the first \$10 per visit for non-emergency treatment by out-of-network providers without a referral, subject to the exclusions.

¹Benefit available after a twelve-month waiting period.

² Applies towards comprehensive orthodontia copayment if patient accepts treatment plan.

This is a summary of common procedures covered in the TrueCare Idaho plan. The policy will control. Please refer to the policy for a complete description of benefits, limitations, and exclusions.

PREMIUM RATES

Premiums are paid on a monthly basis. Payment may be made by personal or cashier's check, money order, Auto Pay (checking account deduction) or credit card (Visa, Mastercard, Discover). If you select Auto Pay, we process payments by checking account on the 5th of each month and payment by credit card on the 6th of each month.

AGE	MONTHLY RATE
0 - 25	\$42.60
26 - 34	\$46.42
35 - 44	\$51.45
45 - 54	\$60.28
55+	\$71.15

**Rates are based on the age of each family member on the date the policy becomes effective. Premiums are adjusted annually. Rates shown are valid through December 31, 2022.*

SUMMARY OF EXCLUSIONS

Please refer to your policy for a complete description of copayments, exclusions and limitations.

- Bridges, crowns, dentures or 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 or services 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.
- Exams or consultations needed solely in connection with a service or supply that is not covered.
- Full mouth reconstruction.
- General anesthesia, moderate sedation, or deep 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, except as covered to correct congenital anomalies in children.
- Prescription and over-the-counter drugs and pre-medications.
- Replacement of lost, missing, stolen or damaged dental appliances.
- Replacement of sound restorations.
- Services 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 by any person other than a licensed dentist, denturist, hygienist, or dental assistant.
- Services for the diagnosis or treatment of temporomandibular joint disorders.
- Services for the treatment of an occupational injury or disease.
- Services for treatment of injuries sustained while practicing for or competing in a professional athletic contest of any kind.
- Services for treatment of intentionally self-inflicted injuries.
- Services for which coverage is available under any federal, state, or other governmental program.
- Services that are not included in the appendices to the policy.
- Services where there is no evidence of pathology, dysfunction, or disease.

CONTACT US

For questions about your bill, to make a payment or to find out the status of your application, please call:

1.855.433.6825 Option 4

If you're not a member yet and have questions about our insurance plan options, please call:

1.855.433.6825 Option 2

To schedule an appointment, please call:

1.855.433.6825 Option 1

For answers to frequently asked questions, visit our website at:

willamettedental.com/individual-plans

TRUECARE IDAHO ENROLLMENT APPLICATION



Willamette
Dental Group

You are eligible for individual coverage under the TrueCare Idaho plan if you are an Idaho resident and are at least 18 years of age. Your eligible dependents include your spouse or domestic partner, child under age 26, and spouse's or domestic partner's child under age 26. Members may not be enrolled under any other insurance plan issued or offered by Willamette Dental of Idaho, Inc. or its affiliates.

To enroll in the TrueCare Idaho plan, complete both sides of this application, including your signature on the back. Please mail the completed application and premium payment to the address below.

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

If we receive your application and premium payment between the 1st and 25th of the month, your coverage will be effective on the first day of the following month. If paying by Auto Pay or credit card, application and payment can be submitted by fax or email to 503-952-2679 or indplans@willamettedental.com.

1 Rate Selection (Select Ages for All Enrollees and Calculate Total Monthly Premium)

Age	# of Enrollees	Monthly Rate	Total Premium Rate per Age Band
<input type="checkbox"/> 0 - 25		X \$42.60 =	
<input type="checkbox"/> 26 - 34		X \$46.42 =	
<input type="checkbox"/> 35 - 44		X \$51.45 =	
<input type="checkbox"/> 45 - 54		X \$60.28 =	
<input type="checkbox"/> 55+		X \$71.15 =	
TOTAL MONTHLY PREMIUM DUE FOR ALL ENROLLEES			=

2 Premium Payment – Please Select Auto Pay or Check

Auto Pay via checking account deduction. Please complete information below - we do not need a voided check.

• Bank Name: _____ Routing Number: _____

• Checking Account Number: _____

Auto Pay via Credit Card: Provide the card information below.

Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover	Credit Card Number:
Expiration Date:	3-Digit Security Code:
Cardholder's Signature:	

If Auto-Pay is selected, I hereby authorize Willamette Dental of Idaho, Inc., to make reoccurring monthly withdrawals from the checking account / credit card listed for the then-current TrueCare Idaho premium amount. This authorization will remain in effect until I have provided notice to Willamette Dental of Idaho, Inc., and my bank with a reasonable amount of time to act upon the notice.

Personal check, cashier's check, or money order: Enclose the first month's premium with this application payable to Willamette Dental of Idaho, Inc.

3 Applicant Enrollment Information

Self (Last, First, Middle Initial):	Social Security Number (not required):		
Requested Effective Date:	Gender:	Date of Birth:	
Mailing Address:	City:	State:	Zip:
Home Phone:	Email Address:		

CONTINUE APPLICATION ON NEXT PAGE...

4 Dependent Enrollment Information

Legal Spouse or Domestic Partner (Last, First, Middle Initial):		
Social Security Number <i>(not required)</i> :	Gender:	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number <i>(not required)</i> :	Gender:	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number <i>(not required)</i> :	Gender:	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number <i>(not required)</i> :	Gender:	Date of Birth:

5 Producer of Record Information *Please note: This section only applies to individuals applying with the help of an insurance agent. Producers are required to have and maintain an Idaho producer license and appointment with Willamette Dental of Idaho, Inc.*

Producer Name:		Agency Name:	
Physical Address:	City:	State:	Zip:
Phone Number:	Email Address:		

6 Acknowledgments and Signature

- I hereby apply for coverage under the TrueCare Idaho policy (Policy Form Number 001TRUE-ID(1/21)), which is a managed care dental policy underwritten by Willamette Dental of Idaho, Inc., 6950 NE Campus Way, Hillsboro, OR 97124, for myself and my listed dependents.
- I authorize providers of services to give Willamette Dental of Idaho, 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 Idaho, Inc., by state or federal law.
- I understand if the application is declined and coverage is not issued, Willamette Dental of Idaho, 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 declined.
- 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 Idaho, Inc., of any change in status within 31 days from the date of change.
- I understand that it may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
- If I choose to sign this application by typing my name below, I acknowledge and agree that my typewritten signature has the same legal effect as my written signature on this application.

Applicant's Signature

Date