TRUECARE
WASHINGTON

Willamette Dental Group

Willamette Dental of Washington, Inc.
6950 NE Campus Way, Hillsboro, OR 97124
For Policy 001TRUE-WA(1/22)
THE POLICY PROVIDES DENTAL BENEFITS ONLY.

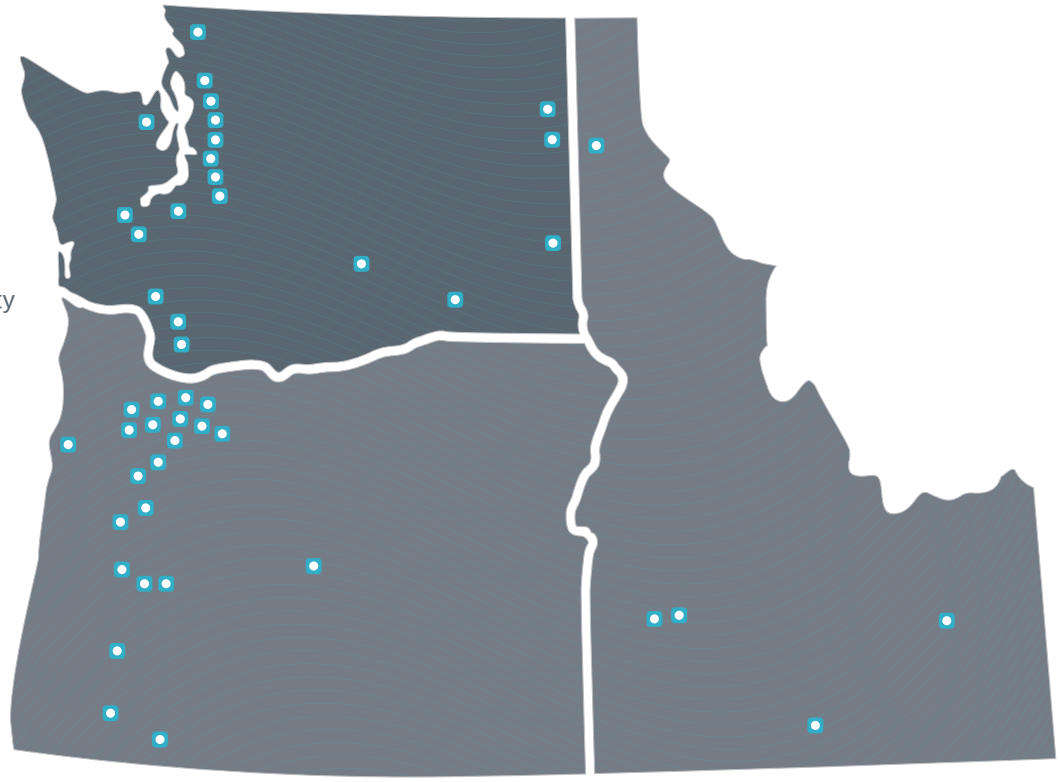
005TRUEWA(1/22)

PERSONAL CARE
FOR YOUR INDIVIDUAL NEEDS

Willamette Dental of Washington, Inc. is pleased to offer you TrueCare Washington. Enjoy no annual maximum and no deductible with predictable copays for covered services. As an enrollee, you simply schedule your appointments at your nearest Willamette Dental Group office to receive your covered benefits.

WASHINGTON LOCATIONS

- Bellevue
- Bellingham
- Everett
- Kent
- Longview
- Mountlake Terrace
- Olympia
- Pullman
- Puyallup
- Richland
- Seattle
- Seattle - Northgate Specialty
- Silverdale
- Spokane - Northpointe
- Spokane Valley
- Tacoma
- Tumwater
- Vancouver - Hazel Dell
- Vancouver - Mill Plain
- Yakima



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 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 Washington 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

COVERED SERVICES	MEMBER BENEFITS
Annual Maximum	No Annual Maximum
Deductible	No Deductible
General O ce Visit	$25 Copay
Specialist O ce 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 / Biscupid 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 is reimbursed up to $100 minus applicable copayments.

[1]Bene t 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 Washington plan. The policy will control. Please refer to the policy for a complete description of bene ts, 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	$45.43
26 - 34	$49.50
35 - 44	$54.87
45 - 54	$64.28
55+	$75.87

**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, 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 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 the treatment of injuries sustained while practicing for or competing in a professional athletic contest of any kind.
- Services for the treatment of intentionally self-inflicted injuries.
- Services for which coverage is available under any federal, state, or other governmental program.
- Services that are not listed as covered in 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 nd out the status of your application, please call:

1.855.433.6825Option 4

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

1.855.433.6825Option 2

To schedule an appointment, please call:

1.855.433.6825Option 1

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

willamettedental.com/truecare-washington

TRUECARE WASHINGTON ENROLLMENT APPLICATION

Willamette Dental Group

You are eligible for individual coverage under the TrueCare Washington plan if you are a Washington 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 o ered by Willamette Dental of Washington, Inc. or its a liates.

To enroll in the TrueCare Washington 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 Washington, Inc.
TrueCare Washington
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 e ective on the rst 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 tcw@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
☐	0 - 25		X	$45.43	=	
☐	26 - 34		X	$49.50	=	
☐	35 - 44		X	$54.87	=	
☐	45 - 54		X	$64.28	=	
☐	55+		X	$75.87	=	
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: ☐ Visa ☐ Mastercard ☐ Discover	Credit Card Number:
Expiration Date:	3-Digit Security Code:
Cardholder's Signature:	

If Auto-Pay is selected, I hereby authorize Willamette Dental of Washington, Inc., to make reoccurring monthly withdrawals from the checking account / credit card listed for the then-current TrueCare Washington premium amount. This authorization will remain in e ect until I have provided 5 business days' prior written notice to Willamette Dental of Washington, Inc., and my bank.

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

3 Applicant Enrollment Information

Self (Last, First, Middle Initial):	Social Security Number (*not required*):		
Requested E ective 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 (*not required*):	Gender:	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number (*not required*):	Gender:	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number (*not required*):	Gender:	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number (*not required*):	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 a Washington producer license and appointment with Willamette Dental of Washington, 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 Washington policy underwritten by Willamette Dental of Washington, Inc., 6950 NE Campus Way, Hillsboro, OR 97124, for myself and 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 bene ts in ful llment of obligations imposed on Willamette Dental of Washington, Inc., by state or federal law.
- I understand 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 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 Washington, Inc., of any change in status within 31 days from the date of change.
- I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, nes, and denial of insurance bene ts.
- If I choose to sign this application by typing my name below, I acknowledge and agree that my typewritten signature has the same legal e ect as my written signature on this application.

Applicant's Signature

Date