Willamette
Dental Group

TrueCare Washington

Form No. 005TRUEWA(7/16)
Policy Form No. 001TRUEWA(7/16)

THE POLICY PROVIDES DENTAL BENEFITS ONLY.

Personal care

for your individual needs

Willamette Dental of Washington, Inc. is pleased to offer you Willamette Dental TrueCare Washington. This policy is true individual dental insurance that offers two options for coverage for your dental care needs. With both options, you enjoy no maximum to the amount of dental services that this policy will cover and there are no deductibles that need to be met. Your coverage gives you simple access to dental care.

On both plan options, 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 also available to both adults and children after a six month waiting period. Participants do not need to fill out or submit claim forms. As an 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 policy keeps that care affordable for you and your family.

With more than 50 Locations

throughout the Pacific Northwest, we're likely to have an office in your neighborhood.

Washington Locations

- Bellevue
- Bellingham
- Everett
- Federal Way
- Kent
- Lakewood
- Longview
- Lynnwood
- Northgate
- Northgate Specialty
- Olympia
- Pullman
- Puyallup
- Richland
- Seattle
- 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 1.855.4DENTAL (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 Willamette Dental 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 Summaries for Plan 1 & Plan 2

Benefit	Plan 1 Copayments	Plan 2 Copayments
Annual Maximum	No Annual Maximum	No Annual Maximum
Deductible	No Deductible	No Deductible
General Office Visit	You pay a $35 Copay	You pay a $25 Copay
Specialist Office Visit	You pay a $35 Copay	You pay a $30 Copay
Dental Exams and X-rays	You pay a $0 Copay	You pay a $0 Copay
Teeth Cleaning	You pay a $0 Copay	You pay a $0 Copay
Fluoride Treatment	You pay a $0 Copay	You pay a $15 Copay
Sealants per Tooth	You pay a $0 Copay	You pay a $15 Copay
Filling - Amalgam	You pay a $45 Copay	You pay a $25 Copay
Filling - Resin (Anterior)	You pay a $70 Copay	You pay $50 Copay
Filling - Resin (Posterior Primary)	You pay $80 Copay	You pay $50 Copay
Filling - Resin (Posterior Permanent)	You pay a $132 Copay	You pay $102 Copay
Stainless Steel Crown	You pay a $90 Copay	You pay $70 Copay
Porcelain/Metal Crown	You pay a $500 Copay [1]	You pay a $400 Copay [1]
Complete Upper or Lower Denture	You pay a $600 Copay [1]	You pay a $500 Copay [1]
Bridge (per tooth)	You pay a $500 Copay [1]	You pay a $400 Copay [1]
Root Canal Therapy – Anterior Tooth	You pay a $225 Copay	You pay a $200 Copay
– Bicuspid Tooth	You pay a $325 Copay	You pay a $225 Copay
– Molar	You pay a $425 Copay	You pay a $250 Copay
Osseous Surgery (per Quadrant)	You pay a $325 Copay	You pay a $300 Copay
Root Planing (per Quadrant)	You pay a $100 Copay	You pay a $75 Copay
Routine Extraction (per Tooth)	You pay a $75 Copay	You pay a $50 Copay
Surgical Extraction (per Tooth)	You pay a $190 Copay	You pay a $100 Copay
Pre-Orthodontic Service	You pay a $150 Copay [2]	You pay a $150 Copay [2]
Comprehensive Orthodontia	You pay a $3,000 Copay [1]	You pay a $2,800 Copay [1]
Nitrous Oxide Per Visit	You pay a $40 Copay	You pay a $40 Copay
Out of area emergency treatment is reimbursed up to $100 minus applicable copayments.		

[1] Benefit available after a six-month waiting period.
[2] Applies towards comprehensive orthodontic copayment if patient accepts treatment plan.

The Willamette Dental TrueCare Washington policy is underwritten by:

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

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 benefits, limitations, and exclusions.

Premium Rates* for Plan 1 & Plan 2

Premiums are paid on a monthly basis. Payment may be made by Auto Pay (checking account deduction), Credit Card, or by personal check. We accept Visa, Mastercard and Discover.

	Monthly Rate	
	Plan 1	Plan 2
Member Only	$49.50	$54.95
Member & Spouse/Partner	$99.00	$109.90
Member & Children	$101.50	$112.65
Member, Spouse/Partner & Children	$151.00	$167.60

**Rates are valid for 12 months from effective date of policy. Rates are subject to change.*

Contact Us

To schedule an appointment, please call:
1.855.433.6825, Option 1

For billing and enrollment information, please call:
1.855.998.2273, Option 1

For benefits and plan information, please call:
1.855.998.2273, Option 3

For answers to frequently asked questions, visit our website at:
www.WillametteDental.com/truecare-washington

Willamette Dental TrueCare Washington Enrollment Application

Willamette Dental Group

You are eligible for individual coverage under the Willamette Dental 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, and spouse's or domestic partner's child. Members may not be enrolled under any other insurance policy or contract issued or offered by Willamette Dental Group or its affiliates.

To enroll in the Willamette Dental TrueCare Washington plan, please complete both sides of this application form, including your signature on the back, and submit along with your premium payment if you are paying by check. You do not need to include a check if paying via Auto Pay or Credit Card.

If you are paying by Auto Pay (checking acct. deduction) or Credit Card, you can submit your completed application in three ways:

- via mail to the address below (you do not need to include your first month's premium payment or a voided check)
- via email to tcw@willamettedental.com
- via fax to 503-952-2679

If you are paying by check, enclose a check for your first month's premium payment with your completed application to the address below.

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

The application and premium payment must be received by the 25th of the month preceding the period for which coverage is to be effective.

1 Type of Enrollment Application

☐ I am a new applicant applying for coverage for myself only.
☐ I am a new applicant applying for coverage for myself & the dependents listed below.

2 Plan Selection

☐ Plan 1 ☐ Plan 2

3 Applicant Enrollment Information

Self (Last, First, Middle Initial):	Requested Effective Date:		
Social Security Number:	Gender: ☐ M ☐ F		Date of Birth:
Mailing Address:	City:	State:	Zip:
Home Phone:	Email Address:		

4 Dependent Enrollment Information

Legal Spouse or Domestic Partner (Last, First, Middle Initial):		
Social Security Number:	Gender: ☐ M ☐ F	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number:	Gender: ☐ M ☐ F	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number:	Gender: ☐ M ☐ F	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number:	Gender: ☐ M ☐ F	Date of Birth:

CONTINUE APPLICATION ON NEXT PAGE...

5 First Month's Premium Payment

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

- Checking Account Number: _____
- Routing Number: _____

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

☐ Personal Check: Enclose a check for the first month's premium with this application payable to Willamette Dental of Washington, Inc.

☐ Credit Card: Provide the card information below.

Card Type: ☐ Visa ☐ Mastercard ☐ Discover	Credit Card Number:
Expiration Date:	3-Digit Security Code:
Cardholder's Signature:	

6 Producer of Record Information *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:		

7 Acknowledgments and Signature

- I hereby apply for coverage under the Willamette Dental 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 benefits in fulfillment 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 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 _____

Summary of Exclusions

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