WAY DENTAL

About Our Dental Savings Plan

The Way Dental Assistance Savings Plan is designed to provide affordability and greater access to quality dental care. Your benefits are available only at Way Dental, 2424 Main St., Evanston, IL.

With your Dental Assistance Savings Plan there are:

- No yearly maximums
- No deductibles
- No claim forms
- No pre-authorization requirements
- No pre-existing condition limitations
- Immediate eligibility (no waiting periods)
- Free consultations

Benefit Premium

Plan	Total Annual Cost
Single	$375.00
Dual*	$700.00
Children**	$275.00
Any Additional Member of the Family***	$325.00

* The Dual Plan is for Parent/Child or Married Couple only

** Children up to the age of 12 only

*** The Family Plan includes family members and children who are enrolled full-time in college until the age of 23, or children who are not enrolled full-time in college until the age of 18

Program Guidelines

- Cannot be used in conjunction with another dental plan
- NON-REFUNDABLE
- No refunds or premiums will be issued at any time if the participant decides not to utilize the dental plan
- Patient's portion of any bill is due on the same day as service
- The plan is in effect once the premiums have been paid
- Cannot be combined with any other promotion, insurance, or any other plan

This program is a discount plan, not a dental insurance plan, and is secondary to any other dental plan. It cannot be used:

- In conjunction with another dental plan
- For services for injuries covered under workman's compensation
- For treatment which, in sole opinion of the treating dentist or doctor, lies outside the realm of their capability
- For referrals to specialists
- For hospitalization or hospital charges of any kind
- For costs of dental care which is covered under automobiled medical

THIS PLAN IS NOT INSURANCE and is not intended to replace your health insurance.

WAY DENTAL

Our Saving Plan Coverage Table

Diagnostic & X-rays

Comprehensive Exam (new patients, initial visit)	100%
Periodic Exam (1 per year) (child under age of 18 - 2 per year)	100%
Limited Oral Exam Problem Focused (1 per year)	100%
Complete Series or Panorex (1 every 3 years)	100%
Periapical, First Film	100%
Periapical, Additional Film	100%
Bitewings (1 time per year)	100%

Preventive

Child Prophylaxis (cleaning) (2 per year)	100%
Adult Prophylaxis (cleaning) (2 per year)	100%
Additional Cleanings per Year	15%
Fluoride (2 per year, no age limit, no copay)	100%
Sealants	15%

All Other Procedures

Fillings and Build-ups	15%
Crowns	15%
Veneers	15%
Periodontics	15%
Dentures and Partials	15%
Oral Surgery	15%
Root Canals	15%
Implants	15%
Periodontal (Deep) Cleanings	15%
Whitening and Orthodontics*** (special discount applies)	

*** For Orthodontics, member must remain a plan member for the duration of treatment to retain discount treatment benefits.

WAY DENTAL

Way Dental Membership

This agreement is by and between Way Dental and _____ ('Patient') constituting our agreement in its entirety. No other warranties, whether written or implied shall apply.

Terms and Conditions

This agreement is to attain active enrollment in the Membership program. This 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.

Membership discounts may not be applicable with other discounts or discounted fee schedules. 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 $10 processing/enrollment fee where permitted by law.

Members who cancel after receiving benefits may be liable for the difference between the Membership fee and the provider's normal and customary fee for treatment, payable to the provider. Members may change providers or add additional family members by providing a written request and paying any additional membership fees. Changes will be effective immediately from acceptance and the receipt of written requests. The Membership does not guarantee the quality or success of any services and/or products offered by individual providers.

The payment due from The Patient is due on the day of active of enrollment. Enrollment shall remain active for a period of one year from the date of enrollment and may be renewed during subsequent years. In subsequent years there may be an increase or decrease of Membership cost and discounts at the discretion of Way Dental. The payment amount to be collected will be in the amount of $375 for primary enrolling member, $700 for member and spouse, $275 for children up to the age of 12 only, and $325 for any additional member of the family.

This agreement will be valid for one year. Any changes to membership status must be authorized by both The Patient and Way Dental. Membership payments are subject to increase in future years, any changes will be given with prior notice to The Patient. Discount rates Way Dental.

Signature _____ Date _____

Discount Plan Members _____

Plan Payment Received by _____ Date _____

Amount _____

WAY DENTAL

Savings Plan Application Form

Your Profile

Name _____ Date of Birth _____

Mailing Address _____

Street Address (if different from above) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Driver License Number & State of Issue _____

Your Spouse's Profile

Name _____ Date of Birth _____

Mailing Address _____

Street Address (if different from above) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Driver License Number & State of Issue _____

Your Children

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Please mail this completed application with the appropriate payment (check or credit card) to:

Way Dental
ATTN: Dental Assistance Savings Plan Coordinator
2424 Main Street
Evanston, IL 60202

Make checks payable to Way Dental.

Credit Card Number _____ Expiration Date _____

Authorized Signature _____ ☐ Visa ☐ MasterCard

I, _____, authorize Way Dental to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the discount plan. Way Dental will notify me when the plan is renewed for my records. If I choose to discontinue participating in the discount plan, I will notify Way Dental one month prior to my anniversary renewal date.

By signing below, I acknowledge that I have read and understand the plan details and limitations.

Signature _____ Date _____

(Signature of plan holder)

* Annual fee is required at enrollment and cannot be financed. Way Dental reserves the right to modify, change or discontinue the Way Dental Savings Plan, fees, terms and services at the company's discretion upon written notice from Way Dental prior to your anniversary renewal date.