



**WBACC Trust
2009**

Dental Insurance Options

Plan Name	Washington Dental Service								Regence BlueShield	
	PPO 1		PPO 2		Enhanced PPO		Enhanced PPO-B		High	Low
Calendar Year Deductible: Individual Family Waived for Class I	\$50 \$150	\$50 \$150	\$50 \$150	\$50 \$150	\$50 \$150	\$50 \$150	\$50 \$150	\$50 \$150	\$50 \$150	\$50 \$150
Calendar Year Maximum Benefit	\$1,000		\$2,000		\$1,500		\$1,500		\$1,000	\$1,000
Providers	Delta PPO	Delta Premier	Delta PPO	Delta Premier	Delta PPO	Delta Premier	Delta PPO	Delta Premier	Regence	Regence
Class I - Diagnostic & Preventive Exams X-Rays Prophyls Fluoride Sealants	100%	80%	100%	80%	100%	100%	100%	100%	100%	100%
Class II - Restorative Restorations Oral Surgery Endodontics Periodontics	80%	70%	80%	70%	90%	80%	90%	80%	80%	80%
Class III - Major Crowns Partials Dentures Bridges Implants	50%	40%	50%	40%	50%	50%	50%	50%	50%	0%
Family Orthodontia Option	50% to \$1,000 Lifetime Maximum		50% to \$1,000 Lifetime Maximum		50% to \$1,000 Lifetime Maximum		50% to \$1,000 Lifetime Maximum		NA	NA
Rates	Dental	With Ortho	Dental	With Ortho	Dental	With Ortho	Dental	With Ortho	Dental	Dental
Employee	\$49.67	\$51.66	\$54.62	\$56.61	\$48.30	\$50.29	\$50.84	\$52.83	\$49.98	\$31.74
Spouse	\$48.89	\$50.98	\$53.80	\$55.89	\$46.71	\$48.80	\$49.17	\$51.26	\$55.26	\$36.26
Child(ren)	\$57.01	\$77.29	\$62.71	\$82.99	\$49.01	\$69.29	\$51.60	\$71.88	\$58.17	\$38.17
Monthly Cost	5+ Required	5+ Required	5+ Required	5+ Required	5+ Required	5+ Required	5+ Required	5+ Required	5+ Required	5+ Required

Plan Name	Willamette Dental Group		Proposal Conditions			
	High Option	Low Option	WDS Except Enhanced PPO-B	WDS Enhanced PPO-B	Regence BlueShield	Willamette Dental Group
Calendar Year Deductible	\$0	\$0				
Calendar Year Maximum Benefit	Unlimited \$1,000 Per Year, \$5,000 Lifetime for TMJ	Unlimited \$1,000 Per Year, \$5,000 Lifetime for TMJ				
General Office Visit	\$15 Copay	\$15 Copay	5	5	5	2
Diagnostic & Preventive Services Exams X-Rays Cleaning Fluoride Sealants	100%	100%				
Cancer Screening Hygiene Instruction	100%	100%				
Periodontal Evaluation & Charting	100%	100%				
Restorative & Prosthetics Fillings Dental Lab Fees	100%	100%				
Permanent Crowns	\$230 Copay	\$295 Copay				
Bridge (Per Tooth)	\$230 Copay	\$295 Copay				
Complete Upper & Lower Denture	\$230 Copay	\$300 Copay				
Endodontics & Periodontics Root Canal - Anterior	\$90 Copay	\$100 Copay				
Root Canal - Bicuspid	\$180 Copay	\$200 Copay				
Root Canal - Molar	\$250 Copay	\$250 Copay				
Osseous Surgery - Per Quadrant	\$150 Copay	\$160 Copay				
Root Planing - Per Quadrant	\$60 Copay	\$75 Copay				
Oral Surgery Routine Extraction - Single Tooth	100%	100%				
Surgical Extraction	\$160 Copay	\$180 Copay				
Family Orthodontia Pre-Orthodontic Service (*Credited To Copay)	\$150*	\$150*				
Comprehensive Orthodontia	\$2,800 Copay	\$2,900 Copay				
Rates	Includes Ortho	Includes Ortho				
Employee	\$42.74	\$37.56				
Spouse	\$39.84	\$35.06				
Child(ren)	\$31.16	\$27.43				
Monthly Cost	\$159.38	\$140.11				



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