WBACC Trust
2009

Dental Insurance Options

	Washington Dental Service							
Plan Name	**PPO 1**		**PPO 2**		**Enhanced PPO**		**Enhanced PPO-B**	
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
Calendar Year Maximum Benefit	$1,000		$2,000		$1,500		$1,500	
Providers	**Delta PPO**	**Delta Premier**	**Delta PPO**	**Delta Premier**	**Delta PPO**	**Delta Premier**	**Delta PPO**	**Delta Premier**
Class I - Diagnostic & Preventive								
Exams | X-Rays | Prophys | Fluoride | Sealants	100%	80%	100%	80%	100%	100%	100%	100%
Class II - Restorative								
Restorations | Oral Surgery | Endodontics | Periodontics	80%	70%	80%	70%	90%	80%	90%	80%
Class III - Major								
Crowns | Partials | Dentures | Bridges | Implants	50%	40%	50%	40%	50%	50%	50%	50%
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	
Rates	**Dental**	**With Ortho**	**Dental**	**With Ortho**	**Dental**	**With Ortho**	**Dental**	**With Ortho**
Employee	$49.10	$51.07	$54.00	$55.97	$47.75	$49.72	$50.26	$52.23
Spouse	$48.33	$50.04	$53.19	$55.26	$46.18	$48.25	$48.61	$50.68
Child(ren)	$56.36	$76.41	$62.00	$82.05	$48.45	$68.50	$51.01	$71.06
	5+ Required	**5+ Required**	**5+ Required**	**5+ Required**	**5+ Required**	**5+ Required**	**5+ Required**	**5+ Required**

	Willamette Dental Group	
Plan Name	**High Option**	**Low Option**
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
Diagnostic & Preventive Services		
Exams | X-Rays | Cleaning | Flouride | Sealants	100%	100%
Cancer Screening | Hygene 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
Endontics & 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 Quandrant	$150 Copay	$160 Copay
Root Planing - Per Quandrant	$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

Proposal Conditions	WDS Except Enhanced PPO-B	WDS Enhanced PPO-B	Willamette Dental Group
Minimum Group Size	5	5	2
Packaging Requirement	Medical	None	None
Eligibility | Enrollment Requirement	Must Match Medical	Stand Alone	Stand Alone
Employer Contibutions	Must Match Medical		
- Minimum For Employees	75%	75%	75%
- Minimum For Dependents	0%	0%	0%
Participation Required	Must Match Medical | 75%	75%	75%

DELTA DENTAL
Washington Dental Service

WILLAMETTE DENTAL