Dental Plan Comparison 2017 - 2018			
	Pioneer Dental	**Kaiser Dental**	**Willamette Dental**
Monthly Premium	Employee Only: $13.85 Employee + 1: $58.48 Family: $115.44	Employee Only: $15.35 Employee + 1: $62.73 Family: $103.16	Employee Only: $11.98 Employee + 1: $43.93 Family: $86.53
Annual Deductible	Individual - $50 Family - $150	None	None
Annual Maximum Benefit	$1,500 per person	$1,500 per person	None
Office Visits	None	$15 copay	$10 copay
Preventive Services: Exams, Cleanings, X-rays, Fluoride	Employee pays 0% (deductible waived)	Fully covered after office visit charge	Fully covered after office visit charge
Basic Services: Fillings, Simple Extractions	Employee pays 20% after deductible	Fully covered after office visit charge	Fully covered after office visit charge
Major Services: Crowns, Bridges, Dentures	Employee pays 50% after deductible	Employee pays 20% Coinsurance	Office visit charge plus: Crown $50 each Bridge $50 per tooth Dentures $100 each
Emergency	Employee pays 20% after deductible	$25 copay in-network Plan pays up to $100 for out-of-area emergency	$50 copay in-network. Plan pays up to $100 for out-of-area emergency
Orthodontia	Employee pays 50% after deductible	Employee pays 50% up to $1,500; 100% thereafter	Pre-orthodontic visit $150, $1,200 treatment co-pay
Orthodontia Lifetime Max	$1,500	$1,500	None

Please note: This summary provides a brief description of the Plan benefits. It is not meant to address all covered services, nor does it address all limitations, exclusions, or instances where prior authorization may be required. Please refer to the Summary Plan Document as it is the binding contract in the event of a discrepancy.