Washington State Council of County and City Employees Health and Welfare Trust

Welfare & Pension Administration Service, Inc.
PO Box 34687
Seattle, WA 98124

PLAN 7

Members: 800-331-6158 option 0
Providers: 800-735-7053 option 3 **Payer ID: 91136** **Group# F36**

SUMMARY OF DENTAL BENEFITS

Calendar Year Maximum: $1000 per person
Deductible: $0

Class I Preventive - 100% up to Usual, Customary and Reasonable Allowances
Class II Basic - 100% up to the fee schedule
Class III Major - 100% up to the fee schedule

FREQUENCY LIMITS	
Bitewing X-rays	Unlimited
Exams	2 per year
Fluoride Treatment	2 per year
Full Mouth Series or Pano	Once every 3 years
Prophy and/or Periodontal Maintenance	4 per year
Sealants – unrestored first and second permanent molars, limited to occlusal surface – for eligible, dependent children under age 18	Once per tooth every 4 years
Perio Scaling and Root Planing – Plan requires mandatory pre-authorization with periodontal chart and x-rays to determine if benefits are allowable.	Once per quadrant every 12 months
ORTHODONTIA	
Available to members and eligible dependents	Treatment must be started while eligible under the Plan.
Percentage payable	50% of Usual, Customary and Reasonable Allowances
Lifetime Orthodontia Maximum	$1,500 per person
MISCELLANEOUS	
Alternative Benefit Provision	Applies to facings on crowns or pontics posterior to the second bicuspid as noted in the dental plan exclusions. Composite restorations on posterior teeth are not reduced to the same surface amalgam allowance.
Date Service Incurred – Seat, Insert, Finish	Patient must be eligible on prep, impression, and start dates as well.
Implants	Effective 09/01/2020, the Plan will cover up to $1,000.00 towards implant related expenses and grafting in addition to the Crown placed on top of the implant. Previously, the Plan covered up to the crown allowance.
Night guards – Predetermination of benefits recommended.	Covered for treatment of bruxism. HABIT BREAKING APPLIANCES ARE NOT COVERED
Nitrous Oxide – or other analgesics	NOT COVERED
Prior Extraction Clause	Teeth must be extracted while insured for initial placement of prosthesis
TMJ	NOT COVERED
Replacement Prosthodontics	Once every 5 year period and only if unserviceable and cannot be made serviceable

If dental care will be extensive, please have the dentist submit a pre-determination of benefits. This will let the dentist and the patient know in advance what procedures are covered, the allowed amount, an estimated payable amount, as well as an estimated patient responsibility.

Benefits are subject to all plan provisions and limitations. Information obtained through this site is not a guarantee of payment and the patient must be eligible on the date(s) services are rendered.

PLAN 7

Annual Maximum: $1,000 (does not apply to Class I or II services for dependent children under the age of 18)
Annual Deductible: $0

LIST OF DENTAL SERVICES
PREVENTIVE SERVICES
Schedule Limit
(Class 1)

ORAL EXAMS (limited to two visits per year)		**Plan 7**
150	Comprehensive oral examination	100% UCR
120	Periodic oral examination	100% UCR
140	Initial oral examination	100% UCR
PROPHYLAXIS (limited to four cleanings per year) **This applies to routine and periodontal prophylaxis combined**		**Plan 7**
1110	Prophylaxis - adult	100% UCR
1120	Prophylaxis - child	100% UCR
4910	Periodontal maintenance procedures (following active therapy)	100% UCR
SEALANTS		**Plan 7**
1351	Sealant - per tooth -Sealants applied to the first and second molars (limited to once each four years and to children under age 18)	100% UCR
TOPICAL FLUORIDE (limited to two treatments per year)		**Plan 7**
1206	Topical application of fluoride varnish	100% UCR
1208	Topical application of fluoride – excluding varnish	100% UCR
X-RAYS		**Plan 7**
210	Intraoral - complete series, including bitewings (limited to once every three years)	100% UCR
220	Intraoral - periapical - first film	100% UCR
230	Intraoral - periapical - each additional film	100% UCR
240	Intraoral - occlusal film	100% UCR
250	Extraoral - first film	100% UCR
260	Extraoral - each additional film	100% UCR
270	Bitewings - single film	100% UCR
272	Bitewings - two films	100% UCR
274	Bitewings - four films	100% UCR
330	Panoramic film - considered a complete series (limited to once each three years)	100% UCR

Usual and Customary Charge (UCR) means the charge for a covered service or supply which is no higher than the 95th percentile of the Plan's most currently available prevailing health care charge data.

BASIC SERVICES
Schedule Limit
(Class 2)

		Plan 7 100% Up to Fee Schedule
ADJUNCTIVE SERVICES		**Plan 7**
9110	Palliative (emergency) treatment of dental pain-minor procedures	$ 64.00
9310	Consultation (diagnostic service provided by Dentist or Physician other than practitioner providing treatment)	$ 55.65
ORAL SURGERY, Extractions (includes local anesthesia and routine postoperative care)		**Plan 7**
7111	Uncomplicated, single	$ 48.00
7140	Each additional tooth	$ 60.00
7220	Extraction, removal of impacted tooth - soft tissue	$ 59.70
7230	Extraction, removal of impacted tooth - partially bony	$ 210.55
7510	Incision and drainage of abscess - intraoral soft tissue	$ 100.00
7960	Frenectomy (frenectomy or frenotomy) – separate procedure	$ 205.00
9220	General anesthesia - first 30 minutes	$ 210.00
PERIODONTICS		**Plan 7**
4210	Gingivectomy or gingivoplasty - per quadrant	$ 200.85
4220	Gingivectomy or gingivoplasty - per tooth	$ 105.00
4341	Periodontal scaling and root planing - per quadrant	$ 164.00
ROOT CANAL THERAPY		**Plan 7**
3310	Anterior (excluding final restoration)	$ 325.00
3320	Bicuspid (excluding final restoration)	$ 415.00
3330	Molar (excluding final restoration)	$ 527.50
RESTORATIVE DENTISTRY		**Plan 7**
2110	Amalgam - one surface, primary	$ 44.75
2120	Amalgam - two surfaces, primary	$ 59.35
2131	Amalgam - four or more surfaces, primary	$ 95.60
2140	Amalgam - one surface, permanent	$ 55.00
2150	Amalgam - two surfaces, permanent	$ 75.00
2161	Amalgam - four or more surfaces, permanent	$ 127.05
2330	Resin - one surface, anterior	$ 64.15
2331	Resin - two surfaces, anterior	$ 105.25
2335	Resin - four or more surfaces or involving incisal angle	$ 128.80

MAJOR SERVICES RESTORATIVE
(Class 3)

Gold restorations and crowns are covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a covered partial denture or fixed bridge.

		Plan 7 100%
		Up to Fee Schedule
INLAYS		**Plan 7**
2510	Inlay - metallic - one surface	$ 140.00
2520	Inlay - metallic - two surfaces	$ 220.00
2530	Inlay - metallic - three surfaces	$ 250.00
2750	Crown - porcelain fused to high noble metal	$ 304.45
2751	Crown - porcelain fused to predominantly base metal	$ 275.00
2790	Crown - full cast high noble metal	$ 304.45
2791	Crown - full cast predominantly base metal	$ 275.00
2920	Recement crown	$ 28.00
2970	Temporary crown (fractured tooth)	$ 54.20
PONTICS		**Plan 7**
6210	Pontic - cast high noble metal	$ 243.65
6211	Pontic - cast predominantly base metal	$ 187.55
6240	Pontic - porcelain fuse to high noble metal	$ 304.45
6250	Pontic - resin with high noble metal	$ 257.15
REMOVABLE		**Plan 7**
5110	Complete upper denture	$ 405.90
5120	Complete lower denture	$ 405.90
5213	Upper partial - resin base (including any conventional clasps, rests and teeth)	$ 439.75
5214	Lower partial - resin base (including any conventional clasps, rests and teeth)	$ 439.75
5520	Replace missing or broken teeth complete denture (each tooth)	$ 55.65
5650	Add tooth to existing partial denture	$ 116.15
ORTHODONTIA		**Plan 7**
	Benefits paid up to:	50%
	Lifetime Maximum	$1,500

The list of services above is not a complete list of covered services.