

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

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

PLAN 1

**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:** \$25 per person/\$75 per family and applied to all services (including preventative)

**Class I Preventive - 80% up to Usual, Customary and Reasonable Allowances**

**Class II Basic - 80% up to the fee schedule**

**Class III Major - 50% up to the fee schedule**

| FREQUENCY LIMITS   |   |
|--|---|
| <b>Bitewing X-rays</b>   | Unlimited   |
| <b>Exams</b>   | 2 per year  |
| <b>Fluoride Treatment</b>  | 2 per year  |
| <b>Full Mouth Series or Pano</b>   | Once every 3 years  |
| <b>Prophy and/or Periodontal Maintenance</b>   | 4 per year  |
| <b>Sealants</b> –unrestored first and second permanent molars, limited to occlusal surface – for eligible, dependent children under age 18                   | Once per tooth every 4 years  |
| <b>Perio Scaling and Root Planing</b><br>Plan requires mandatory pre-authorization with periodontal chart and x-rays to determine if benefits are allowable. | Once per quadrant every 12 months   |
| ORTHODONTIA  |   |
| NOT COVERED  |   |
| MISCELLANEOUS  |   |
| <b>Alternative Benefit Provision</b>   | 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.       |
| <b>Date Service Incurred</b> – Seat, Insert, Finish  | Patient must be eligible on prep, impression, and start dates as well.  |
| <b>Implants</b>  | 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. |
| <b>Night guards – Predetermination of benefits recommended.</b>  | Covered for treatment of bruxism. HABIT BREAKING APPLIANCES ARE NOT COVERED   |
| <b>Nitrous Oxide</b> – or other analgesics   | NOT COVERED   |
| <b>Prior Extraction Clause</b>   | Teeth must be extracted while insured for initial placement of prosthesis   |
| <b>TMJ</b>   | NOT COVERED   |
| <b>Replacement Prosthodontics</b>  | 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.*

|               |
|---------------|
| <b>PLAN 1</b> |
|---------------|

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

**Annual Deductible: \$25 per person/\$75 per family and applied to all services (including preventative)**

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

|  |   |               |
|--|---|---------------|
| <b>ORAL EXAMS (limited to two visits per year)</b>   |   | <b>Plan 1</b> |
| 150  | Comprehensive oral examination  | 80% UCR       |
| 120  | Periodic oral examination   | 80% UCR       |
| 140  | Initial oral examination  | 80% UCR       |
| <b>PROPHYLAXIS (limited to four cleanings per year)<br/>This applies to routine and periodontal prophylaxis combined</b> |   | <b>Plan 1</b> |
| 1110   | Prophylaxis - adult   | 80% UCR       |
| 1120   | Prophylaxis - child   | 80% UCR       |
| 4910   | Periodontal maintenance procedures (following active therapy)   | 80% UCR       |
| <b>SEALANTS</b>  |   | <b>Plan 1</b> |
| 1351   | Sealant - per tooth -Sealants applied to the first and second molars (limited to once each four years and to children under age 18) | 80% UCR       |
| <b>TOPICAL FLUORIDE (limited to two treatments per year)</b>   |   | <b>Plan 1</b> |
| 1206   | Topical application of fluoride varnish   | 80% UCR       |
| 1208   | Topical application of fluoride – excluding varnish   | 80% UCR       |
| <b>X-RAYS</b>  |   | <b>Plan 1</b> |
| 210  | Intraoral - complete series, including bitewings (limited to once every three years)  | 80% UCR       |
| 220  | Intraoral - periapical - first film   | 80% UCR       |
| 230  | Intraoral - periapical - each additional film   | 80% UCR       |
| 240  | Intraoral - occlusal film   | 80% UCR       |
| 250  | Extraoral - first film  | 80% UCR       |
| 260  | Extraoral - each additional film  | 80% UCR       |
| 270  | Bitewings - single film   | 80% UCR       |
| 272  | Bitewings - two films   | 80% UCR       |
| 274  | Bitewings - four films  | 80% UCR       |
| 330  | Panoramic film - considered a complete series (limited to once each three years)  | 80% 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)**

|   |  | <b>Plan 1</b><br><b>80%</b>         |
|---|--|-------------------------------------|
|   |  | <b>Up to Fee</b><br><b>Schedule</b> |
| <b>ADJUNCTIVE SERVICES</b>  |  | <b>Plan 1</b>                       |
| 9110  | Palliative (emergency) treatment of dental pain-minor procedures   | \$ 43.00                            |
| 9310  | Consultation (diagnostic service provided by Dentist or Physician other than practitioner providing treatment) | \$ 39.00                            |
| <b>ORAL SURGERY, Extractions (includes local anesthesia and routine postoperative care)</b> |  | <b>Plan 1</b>                       |
| 7111  | Uncomplicated, single  | \$ 33.00                            |
| 7140  | Each additional tooth  | \$ 41.00                            |
| 7220  | Extraction, removal of impacted tooth - soft tissue  | \$ 90.00                            |
| 7230  | Extraction, removal of impacted tooth - partially bony   | \$ 125.00                           |
| 7510  | Incision and drainage of abscess - intraoral soft tissue   | \$ 70.00                            |
| 7960  | Frenectomy (frenectomy or frenotomy) – separate procedure  | \$ 145.00                           |
| 9220  | General anesthesia - first 30 minutes  | \$ 135.00                           |
| <b>PERIODONTICS</b>   |  | <b>Plan 1</b>                       |
| 4210  | Gingivectomy or gingivoplasty - per quadrant   | \$ 138.00                           |
| 4220  | Gingivectomy or gingivoplasty - per tooth  | \$ 75.00                            |
| 4341  | Periodontal scaling and root planing - per quadrant  | \$ 83.50                            |
| <b>ROOT CANAL THERAPY</b>   |  | <b>Plan 1</b>                       |
| 3310  | Anterior (excluding final restoration)   | \$ 235.00                           |
| 3320  | Bicuspid (excluding final restoration)   | \$ 285.00                           |
| 3330  | Molar (excluding final restoration)  | \$ 338.80                           |
| <b>RESTORATIVE DENTISTRY</b>  |  | <b>Plan 1</b>                       |
| 2110  | Amalgam - one surface, primary   | \$ 31.00                            |
| 2120  | Amalgam - two surfaces, primary  | \$ 40.00                            |
| 2131  | Amalgam - four or more surfaces, primary   | \$ 55.00                            |
| 2140  | Amalgam - one surface, permanent   | \$ 38.00                            |
| 2150  | Amalgam - two surfaces, permanent  | \$ 52.00                            |
| 2161  | Amalgam - four or more surfaces, permanent   | \$ 76.00                            |
| 2330  | Resin - one surface, anterior  | \$ 43.00                            |
| 2331  | Resin - two surfaces, anterior   | \$ 58.00                            |
| 2335  | Resin - four or more surfaces or involving incisal angle   | \$ 87.00                            |

**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.

|                  |  | <b>Plan 1<br/>50%</b>         |
|------------------|--|-------------------------------|
|                  |  | <b>Up to Fee<br/>Schedule</b> |
| <b>INLAYS</b>    |  | <b>Plan 1</b>                 |
| 2510             | Inlay - metallic - one surface   | \$ 135.00                     |
| 2520             | Inlay - metallic - two surfaces  | \$ 165.00                     |
| 2530             | Inlay - metallic - three surfaces  | \$ 180.00                     |
| 2750             | Crown - porcelain fused to high noble metal  | \$ 247.50                     |
| 2751             | Crown - porcelain fused to predominantly base metal                                | \$ 203.00                     |
| 2790             | Crown - full cast high noble metal   | \$ 203.50                     |
| 2791             | Crown - full cast predominantly base metal   | \$ 180.00                     |
| 2920             | Recement crown   | \$ 20.00                      |
| 2970             | Temporary crown (fractured tooth)  | \$ 44.00                      |
| <b>PONTICS</b>   |  | <b>Plan 1</b>                 |
| 6210             | Pontic - cast high noble metal   | \$ 198.00                     |
| 6211             | Pontic - cast predominantly base metal   | \$ 152.35                     |
| 6240             | Pontic - porcelain fuse to high noble metal  | \$ 247.50                     |
| 6250             | Pontic - resin with high noble metal   | \$ 209.00                     |
| <b>REMOVABLE</b> |  | <b>Plan 1</b>                 |
| 5110             | Complete upper denture   | \$ 330.00                     |
| 5120             | Complete lower denture   | \$ 330.00                     |
| 5213             | Upper partial - resin base<br>(including any conventional clasps, rests and teeth) | \$ 357.50                     |
| 5214             | Lower partial - resin base (including any conventional<br>clasps, rests and teeth) | \$ 357.50                     |
| 5520             | Replace missing or broken teeth complete denture (each<br>tooth)                   | \$ 20.50                      |
| 5650             | Add tooth to existing partial denture  | \$ 69.30                      |

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