WASHINGTON STATE COUNCIL OF COUNTY AND CITY EMPLOYEES AFSCME AFL-CIO

DENTAL PLAN VIII

HOW TO OBTAIN PLAN BENEFITS

To obtain benefits see the Payment of Claims provision.

Forward Your completed claim form to:
Zenith Administrators, Inc.
201 Queen Anne Avenue North
Seattle, Washington 98109

SCHEDULE

For You and Your Dependents
DENTAL BENEFITS
(Class 8)

<u>Percentage Payable</u> Preventive, Basic and Major Services
The Plan will pay 100% of the covered Expense up to the UCR Limit for preventive and as shown in the List of Dental Services for other benefits.

<u>Covered Orthodontia:</u>
The Plan will pay 50% of the covered Expense up to the maximum for Covered Services.

<u>Deductible</u>
None

<u>Calendar Year</u>
January 1 through December 31 of the same year.

<u>Maximum</u>
Preventive, Basic and Major Services Combined: $2,000 each calendar year for each Covered Person.

<u>Covered Orthodontia</u>
$1,500 for each Covered Person while insured under the Plan.

DENTAL BENEFITS
For You and Your Dependents

<u>Benefits</u>
If You or Your dependent, while covered under this provision, incurs Expense for Covered Services as shown on the List Of Dental Services, the Plan will pay the Usual and Customary Charges for Preventive Services as described in the Schedule beginning on page 13 and a percentage of the covered dental expense not to exceed the limit shown in the Schedule for all other services after the Deductible is satisfied. The Plan will pay up to the Maximum for each Covered Person. The **Percentage Payable**, **Deductible** and **Maximum** for the Class (Classes) of Services for which You or Your dependent are covered are shown in the Schedule. A charge will be considered to be incurred on the date the service is received.

<u>Extension of Benefits</u>
When coverage provided under this provision has ended with respect to a Covered Person, coverage will be extended for completion of services for which a course of treatment was started by a Dentist prior to the date coverage ended. In no event will the Plan be liable for such extended completion work which takes place more than 30 days after coverage ends. This Extension of Benefits will operate only to the extent that coverage for the services is not otherwise provided for the Covered Person through the Plan.

<u>General Exclusions and Limitations</u>
The Plan will not pay for any Expense or charge:
(a) which is in excess of the scheduled fee amount;

LIST OF DENTAL SERVICES
PREVENTIVE SERVICES
Schedule Limit
(Class 8)

ORAL EXAMS (limited to two visits per year)

Code	Service	Limit
150	Comprehensive oral examination	UCR
120	Periodic oral examination	UCR
140	Initial oral examination	UCR

PROPHYLAXIS (limited to four cleanings per year)
This applies to routine and periodontal prophylaxis combined

Code	Service	Limit
1100	Prophylaxis - adult	UCR
1120	Prophylaxis - child	UCR
4910	Periodontal maintenance procedures (following active therapy)	UCR

SEALANTS

Code	Service	Limit
1351	Sealant - per tooth -Sealants applied to the first and second molars (limited to once each four years and to children under age 18)	UCR

TOPICAL FLUORIDE (limited to two treatments per year)

Code	Service	Limit
1203	Topical application of fluoride - under age 14	UCR
1204	Topical application of fluoride - age 14 - 18	UCR

X-RAYS

Code	Service	Limit
210	Intraoral - complete series, including bitewings (limited to once every three years)	UCR
220	Intraoral - periapical - first film	UCR
230	Intraoral - periapical - each additional film	UCR
240	Intraoral - occlusal film	UCR
250	Extraoral - first film	UCR
260	Extraoral - each additional film	UCR
270	Bitewings - single film	UCR
272	Bitewings - two films	UCR
274	Bitewings - four films	UCR
330	Panoramic film - considered a complete series (limited to once each three years)	UCR

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

BASIC SERVICES
Schedule Limit (Class 8)

ADJUNCTIVE SERVICES

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 (includes local anesthesia and routine postoperative care)

Extractions

7110	Uncomplicated, single	$ 60.00
7120	Each additional tooth	$ 55.00
7220	Extraction, removal of impacted tooth - soft tissue	$159.70
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

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

3310	Anterior (excluding final restoration)	$325.00
3320	Bicuspid (excluding final restoration)	$415.00
3330	Molar (excluding final restoration)	$527.50

RESTORATIVE DENTISTRY

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

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.

INLAYS

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

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

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

COVERED ORTHODONTIA CHARGES

If You or Your dependent, while covered under this provision, incur Expense for Covered Orthodontia Charges, the Plan will pay the Expense incurred, not to exceed the percentage payable or the maximum shown in the Schedule for Covered Orthodontia Services.

Covered Orthodontia Charges are charges for Expense incurred for an Orthodontic Procedure started while insured under this provision.