SOUND HEALTH & WELLNESS TRUST

DENTAL OPTIONS

FOR

Sound Plan

2012

COMPARISON OF DENTAL BENEFITS
EFFECTIVE JANUARY 2012

Sound Health & Wellness Trust

COMPARISON OF DENTAL BENEFITS EFFECTIVE JANUARY 2012

Sound Plan

	WDS Preferred Program #09136	DeltaCare Program #00405	Schedule Plan #09393
How it Works	This option requires you to choose from a list of dentists in a managed care network. Your reimbursement will depend on the providers contract with WDS: • WDS/Delta Dental Preferred (PPO) Providers: Seeing a Preferred Dentist will provide the highest level of benefits and may provide the lowest out of pocket costs. • WDS/Delta Dental Participating Providers: These Dentists provide a discount, but your benefits percentage is lower and may result in higher out of pocket costs vs. a Preferred Dentist. • Non-WDS Dentist: If your Dentist is not Preferred or Participating, your benefits will be lower, and you may have higher out of pocket costs. Reimbursement is made based on maximum allowable fees, which may leave you with a higher patient responsibility.	DeltaCare is a dental HMO plan. This option requires you to choose from a list of approved dentists and clinics. You MUST choose a DeltaCare primary care dentist who coordinates all of your care, including any referrals to specialists. Under this plan you cannot just see any licensed dentist for treatment. A list of DeltaCare providers can be found at www.deltadentalwa.com. Make sure you have a DeltaCare provider in your area before enrolling in this option.	This option allows you to see any licensed dental provider. Benefits will be paid according to the schedule of allowances. Dental charges in excess of the schedule will be your responsibility.

The Trustees do not promise to continue any individual benefit or any level of benefits for any set period of time. They have the right to change, suspend, or discontinue a benefit under the plan at any time. Changes they make will take effect only after notice to participants.

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Annual Deductible (per calendar year) • **Individual** • **Family**	$10 $30	None None	$10 $30
Annual Maximum (per calendar year)	$2,500 per person	None	$2,500 per person
Coinsurance Class I Procedures: • Diagnostic • Preventative	***WDS/Delta Dental Participating Dentist*** 100% of charges for preferred providers 75% of charges for non preferred providers ***Non WDS Participating Dentist*** 75% of allowable fees	Covered procedures are provided with no co-payment when performed by an assigned DeltaCare Dentist. (See attached schedule)	Paid per Plan's Schedule of Allowances. (See attached schedule)
Class II Procedures: • Restorations • Oral Surgery • Periodontics • Endodontics • General Anesthesia • Intravenous Sedation	***WDS/Delta Dental Participating Dentist*** 85% of charges for preferred providers 75% of charges for non preferred providers ***Non WDS Participating Dentist*** 75% of allowable fees	Covered procedures are provided with copays. (See attached schedule)	Paid per Plan's Schedule of Allowances. (See attached schedule)

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Class III Procedures: • Crowns • Dentures • Bridges • Partials	***WDS/Delta Dental Participating Dentist*** 50% of charges for preferred providers 40% of charges for non preferred providers ***Non WDS Participating Dentist*** 40% of allowable fees	Covered procedures are provided with copays. (See attached schedule)	Paid per Plan's Schedule of Allowances. (See attached schedule)
Orthodontia	Not covered	Not covered	Not covered
Implants	Not covered	Not covered	Paid per Plan's Schedule of Allowances. (See attached schedule)

Sound Plan – WDS PREFERRED PROGRAM #09136

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BENEFITS COVERED BY YOUR PROGRAM

The following are Class I, Class II and Class III Covered Dental Benefits under this program that are subject to the limitations and exclusions contained in this summary. Such benefits *(as defined)* are available only when rendered by a licensed Dentist or other WDS-approved Licensed Professional when appropriate and necessary as determined by the standards of generally accepted dental practice and WDS.

The amounts payable by WDS for Class I, II and III Covered Dental Benefits are described elsewhere. Refer to General Limitations and General Exclusions (as shown on pages 4 & 5).

CLASS I

DIAGNOSTIC

Covered Dental Benefits

- Routine examination (periodic oral evaluation).
- Comprehensive oral evaluation.
- X-rays.
- Emergency examination.
- Specialist examination performed by a specialist in an American Dental Association recognized specialty (i.e. endodontist, periodontist, etc.).

Limitations

- Routine examination is covered twice in a calendar year.
- Comprehensive oral evaluation is covered once in a 3-year period as one of the two covered examinations in a calendar year per eligible person per dental office. Additional comprehensive oral evaluations will be allowed as routine examinations. You will not be responsible for any difference in cost when services are provided by a WDS dentist.
- Complete series (any number or combination of intraoral x-rays, billed for same date of service, that equals or exceeds the allowed fee for a complete series is considered a complete series for payment purposes) or panorex x-rays are covered once in a 3-year period from the date of service.
- Supplementary bitewing x-rays are covered twice in a calendar year.
- Diagnostic services and x-rays related to temporomandibular joints (jaw joints) are not a paid covered benefit under Class I Benefits.

Exclusions

- Consultations or elective second opinions.
- Study models.
- Caries susceptibility/risk tests.

PREVENTIVE

Covered Dental Benefits

- Prophylaxis (cleaning).
- Periodontal maintenance.
- Fissure sealants.
- Topical application of fluoride or preventive therapies (e.g., fluoridated varnishes).
- Space maintainers when used to maintain space for eruption of permanent teeth.

Limitations

- Prophylaxis cleaning and/or periodontal maintenance procedures will be limited to 2 procedures in a calendar year.
- Topical application of fluoride or preventive therapies *(but not both)* is covered twice in a calendar year through age 18.
- Fissure sealants are available for children through age 15. If eruption of permanent molars is delayed, sealants will be allowed if applied within 12 months of eruption with documentation from the attending Dentist. Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface. The application of fissure sealants is a covered benefit once in a lifetime per tooth.
- Replacement of a space maintainer previously paid for by WDS is not a covered benefit.

Exclusions

- Charges for home use supplies such as toothpaste, toothbrush, water-pick, fluoride, mouthwash, dental floss, etc.
- Oral hygiene and/or dietary instruction or for a plaque control program (a series of instructions on the care of the teeth)

REFER TO GENERAL LIMITATIONS AND GENERAL EXCLUSIONS

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CLASS II

Note: *Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins*

GENERAL ANESTHESIA

Covered Dental Benefits

- General anesthesia when administered in a dental office setting by a licensed Dentist or other WDS-approved Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.

Limitations

- General anesthesia is covered in conjunction with certain covered oral surgery procedures, as determined by WDS, or when medically necessary, for children through age 6, or a physically or developmentally disabled person, when in conjunction with Class I, II and III covered dental procedures. Either general anesthesia or intravenous sedation (but not both) is covered when performed on the same day.
- General anesthesia for routine post-operative procedures is not a covered benefit.

INTRAVENOUS SEDATION

Covered Dental Benefits

- Intravenous sedation when administered by a licensed Dentist or other WDS-approved Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are delivered.

Limitations

- Intravenous sedation is covered in conjunction with certain covered oral surgery procedures, as determined by WDS. Either general anesthesia or intravenous sedation (but not both) is covered when performed on the same day.
- Intravenous sedation for routine post-operative procedures is not a covered benefit.

PALLIATIVE TREATMENT

Covered Dental Benefits

- Palliative treatment for pain.

Limitations

- Palliative treatment is Not a Paid Covered Benefit when the same provider performs any other definitive treatment on the same date.

RESTORATIVE

Covered Dental Benefits

- Silver fillings (amalgam) and, in front (anterior) teeth, "white" (resin-based composite or glass ionomer restorations) fillings for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp).
- "White" (resin-based composite or glass ionomer restorations) fillings placed in the buccal (facial) surface of bicuspids.
- Stainless steel crowns.

Limitations

- Fillings (restorations) on the same surface(s) of the same tooth are covered once in a 2-year period from the date of service.
- If a resin-based composite restoration is placed in a posterior tooth, (except on bicuspids as noted above), an amalgam allowance will be made for such procedure. The difference in cost is your responsibility.
- Cosmetic services are not a covered benefit.
- Stainless steel crowns on permanent or primary teeth are covered once in a 2-year period from the date of service.
- **Refer to Class III Restorative if teeth are restored with crowns, veneers, inlays or onlays.**

Exclusions

- Overhang removal, copings, re-contouring or polishing of fillings (restorations).

ORAL SURGERY

Covered Dental Benefits

- Removal of teeth and surgical extractions.
- Preparation of the upper jaw or lower jaw and soft tissue of the mouth for insertion of dentures.
- Treatment of pathological conditions and traumatic facial injuries of the mouth.
- Refer to Class II General Anesthesia or Intravenous Sedation for additional information.

Exclusions

- Bone replacement graft for ridge preservation.
- Bone grafts of any kind to the upper or lower jaws not associated with periodontal treatment of teeth.
- Tooth transplants.
- Materials placed in extraction sockets.

PERIODONTICS

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth. Services covered include periodontal scaling/root planing, gingivectomy and limited adjustments to the chewing surface of the teeth (occlusion) for 8 teeth or less.

Limitations

- Periodontal scaling/root planing is covered once in a 24-month period from the date of service.
- Limited occlusal adjustments are covered once in a 12-month period from the date of service.
- Periodontal surgery (per site) is covered once in a 3-year period from the date of service.
- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances are not a paid covered benefit.

Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered benefit. A predetermination is not a guarantee of payment.

Exclusions

- Occlusal guard (nightguard) and occlusal splints.
- Gingival curettage.
- Major (complete) occlusal adjustment to the chewing surface of the teeth.

ENDODONTICS

Covered Dental Benefits

- Procedures for pulpal and root canal treatment.
- Services covered include pulpotomy and apicoectomy.

Limitations

- Root canal treatment on the same tooth is covered only once in a 2-year period from the date of service.
- Re-treatment of the same tooth is allowed when performed by a different dental office.

Refer to Class III Prosthodontics if the root canals are placed in conjunction with a prosthetic appliance.

Exclusions

- Bleaching of teeth.

REFER TO GENERAL LIMITATIONS AND GENERAL EXCLUSIONS

CLASS III

Note: *Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins*

RESTORATIVE

Covered Dental Benefits

- Crowns, veneers or onlays for treatment of visible destruction of hard tooth structure resulting from the process of dental decay, or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored by a less costly treatment.
- Crown buildups, subject to limitations.
- Post and core, subject to limitation.

Limitations

- Crowns, veneers or onlays on the same teeth are covered once in a 5-year period from the seat date. If a porcelain onlay is placed on a tooth, an allowance for a metallic onlay will be made for such procedure. The difference in cost is your responsibility. If a tooth can be restored with a filling material such as amalgam or resin-based composite, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided. WDS will allow the appropriate amount for an amalgam restoration (posterior tooth) or resin-based composite restoration (anterior tooth) toward the cost of a laboratory processed resin inlay (as a single tooth restoration - with limitations), onlay, veneer or crown.
- Payment for crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays shall be paid upon the seat date.

- Crown buildups are a covered benefit when more than 50% of the visible portion of the tooth structure is missing or there is less than 2mm of vertical height remaining for one-half or more of the tooth circumference and there is evidence of decay or other significant breakdown.
- Crown buildups are covered once in a 2-year period from the date of service.
- Crown buildups are not a paid covered benefit within 2 years of a restoration on the same tooth.
- Crown buildups for the purpose of improving tooth form, filling in undercuts, or reducing bulk in castings are considered basing materials and are not a paid covered benefit.
- Post and core are covered once in a five-year period from the date of service on the same tooth.
- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.
- Crowns or onlays are not a covered benefit when used to repair microfractures of tooth structure when the tooth displays no symptoms or there are existing restorations with defective margins when there is no decay.
- Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a paid covered benefit.
- Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a paid covered benefit.

Exclusions

- Copings.

PROSTHODONTICS

Covered Dental Benefits

- Dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge), removable partial dentures and the adjustment or repair of an existing prosthetic device.

Limitations

- Replacement of an existing prosthetic device is covered only once every 5 years from the date of service and only then if it is unserviceable and cannot be made serviceable.
- Inlays are a covered benefit on the same teeth once in a 5-year period from the date of service only when used as an abutment for a fixed bridge.
- Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge) and removable partial dentures shall be paid upon the delivery date.
- Crowns in conjunction with overdentures are not a paid covered benefit.
- Root canals in conjunction with overdentures are not a paid covered benefit.
- Fixed prosthodontics for children under 16 years of age are not a paid covered benefit.
- Porcelain and resin inlay bridges are not a paid covered benefit.
- **Full, immediate dentures** - WDS will allow the appropriate amount for a full or immediate denture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment.
- **Partial dentures** - If a more elaborate or precision device is used to restore the case, WDS will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided.
- **Temporary partial dentures** - Temporary (stayplate) dentures are a benefit only when replacing anterior teeth during the healing period or in children 16 years of age or under for missing anterior permanent teeth.
- **Denture adjustments and relines** - Denture adjustments done more than 6 months after the initial placement are covered twice in a l2-month period. Relines done more than 6 months after the initial placement are covered. Subsequent relines or rebases (but not both) will be covered once in a 12 month period from the date of service.

Exclusions

- Duplicate dentures.
- Personalized dentures.
- Cleaning of prosthetic appliances.
- Copings.
- Temporary dentures.
- Implants.

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Sound Plan – WDS PREFERRED PROGRAM #09136

REFER TO GENERAL LIMITATIONS AND GENERAL EXCLUSIONS

ACCIDENTAL INJURY

Washington Dental Service will pay 100% of participating providers filed fee or the maximum allowable fee for covered dental benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused program maximum. The accidental bodily injury must have occurred while the patient was eligible. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

GENERAL LIMITATIONS

- Services for cosmetic reasons is not a covered benefit.
- General anesthesia/intravenous (deep) sedation, except as specified for oral surgery procedures. General anesthesia except when medically necessary, for children through age 6, or a physically or developmentally disabled person, when in conjunction with covered dental procedures.
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures, which include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth, are not covered.

GENERAL EXCLUSIONS

- Care for any dental condition, ailment, or injury for which you or your dependent are entitled to receive benefits in whole or in part under occupational coverage voluntarily obtained by the employer or required by Workers' Compensation of the United States or services rendered in a hospital owned or operated by a State or United States Government Agency or any care for which benefits are available under any State or Federal Act, even though the member and/or their dependent waives their right to such benefits.
- Application of desensitizing agents.
- Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, WDS, in conjunction with the American Dental Association, will consider if: 1) the services are in general use in the dental community in the State of Washington; 2) the services are under continued scientific testing and research; 3) the services show a demonstrable benefit for a particular dental condition; and 4) they are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
- Analgesics such as nitrous oxide, conscious sedation, euphoric drugs, injections or prescription drugs.
- In the event an eligible participant fails to obtain a required examination from a WDS-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
- Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
- Broken appointments.
- Patient management problems.
- Completing insurance forms.
- Habit-breaking appliances.
- Orthodontic services or supplies.
- TMJ services or supplies.
- This plan does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, under-insured motorist, personal injury protection (PIP), commercial liability, homeowner's policy or other similar type of coverage.
- Claims received after the 12 month filing limit.
- Charges made after coverage ends, except for the completion within 30 days of single procedures commenced while this coverage was in effect.
- Charges that exceed the maximum benefits.
- Conditions caused by or arising from an act of war, armed invasion or aggression.
- Expenses incurred before you became eligible.
- Expense incurred from a suicide attempt or intentionally self-inflicted injury or illness.
- Phone or other consultants when a dentist does not physically see a patient.
- Prescription drugs.

- Replacement of prosthodontic device or orthodontic appliance that is lost, stolen or damaged by neglect.
- Separate asepsis or sterilization charges.
- Services primarily for patient or provider convenience.
- All other services not specifically included in this program as covered dental benefits.
- Bleaching of teeth.

WDS shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in this summary, but it shall not exercise this authority arbitrarily or capriciously or in violation of the provisions of the plan.

Sound Plan– DELTACARE
PROGRAM #00405

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Sound Plan– DELTACARE PROGRAM #00405

Feature	Plan	Limitations and Exclusions
Plan Description	The Plan is a Dental Health Maintenance (DHMO) managed care dental plan. When you select this plan, you will select a DeltaCare dentist for yourself and your family members at the time of enrollment. ***Only treatment provided by a DeltaCare dentist will be covered.***	**Within the DeltaCare plan, in order to change providers, you MUST contact the DeltaCare Unit of Washington Dental Service at (800) 650-1583.**
Diagnostic & Preventive Services (*Exams, cleanings, x-rays, fluoride)*	Covered procedures are provided with no co-payment when performed by the assigned DeltaCare dentist. Subject to plan exclusions and limitations.	Fluoride is covered twice in a benefit year thru age 18. Full mouth x-rays are covered once every three years. Four bitewing x-rays are covered once every six months.
Restorations *(Fillings)* **Endodontics** *(Root canal therapy)* **Periodontics** *(Gum & bone therapy)* **Oral Surgery** *(Tooth Removal)*	Covered procedures are provided with no co-payment when performed by the assigned DeltaCare dentist. Please see the applicable co-payment schedule.	Subject to plan exclusion & limitations. General anesthesia is not a covered benefit except for children under 6 and disabled subscribers.
Crowns	Co-payments will apply to limited crown procedures. Please see the applicable co-payment schedule.	Crowns are covered once in a 5 year period.
Prosthodontics *(Removable and fixed dentures)*	Co-payments will apply. Please see the applicable co-payment schedule.	Dentures & bridges are covered once in a 5 year period.
Maximum Benefit Paid and Deductibles	No annual maximum or deductible.	
Benefit Period	January 1 through December 31.	
Orthodontia	Not covered	
Emergency Services *(Immediate pain relief)*	All emergency services must be coordinated through your selected DeltaCare dentist.	When traveling out of your local area, emergency stabilization care will be limited to a maximum of $100.00 per year, after any applicable co-payments.
Implants	Not covered	

This is for general benefit information only. For complete details on your Washington Dental Service benefits, please see your DeltaCare Booklet.
To reach The DeltaCare Unit at Washington Dental Service, please call 1-800-650-1583 - **SHWT Dental Benefits page: www.DeltaDentalWA.com**

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Sound Plan– DELTACARE PROGRAM #00405

Patient Co-Payment Schedule

The patient co-pay schedule shows what you will pay when you receive treatment from a DeltaCare provider.

CODE	PROCEDURE	
DIAGNOSTIC & PREVENTIVE		**Patient Co-Pay**
D0120	Periodic oral examination – established patient	$0.00
D0125	Failed Appointment without 24 hr notice per 15 min of appt time	$10.00
D0140	Limited oral evaluation-problem focused	$15.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$15.00
D0150	Comprehensive oral evaluation	$0.00
D0160	Detailed and extensive oral evaluation - problem focused	$0.00
D0170	Re-evaluation-limited, problem focused (Established pt not post op visit)	$0.00
D0180	Comprehensive Periodontal Exam	$0.00
	Specialist Exam (For use by specialist for above codes)	$0.00
D0210	Intraoral - complete series, including bitewings	$0.00
D0220	Intraoral - periapical, first film	$0.00
D0230	Intraoral - periapical, each additional film	$0.00
D0240	Intraoral - occlusal film	$0.00
D0270	Bitewing - single film	$0.00
D0272	Bitewings - two films	$0.00
D0273	Bitewings – three films	0.00
D0274	Bitewings - four films	$0.00
D0330	Panoramic film	$0.00
D0460	Pulp vitality tests	$0.00
D0470	Diagnostic casts	$0.00
D1110	Prophylaxis - adult	$0.00
D1120	Prophylaxis - child	$0.00
D1203	Topical application of fluoride excluding prophylaxis - child to age 19	$0.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients – *child to age 19; 1 per 6 month period*	$0.00
D1330	Oral hygiene instruction	$0.00
D1351	Sealant - per tooth	$5.00
D1510	Space maintainer - fixed, unilateral	$24.00
D1515	Space maintainer - fixed, bilateral	$34.00
D1520	Space maintainer - removable, unilateral	$25.00
D1525	Space maintainer - removable, bilateral	$32.00
D1550	Recementation of space maintainer	$10.00
D1555	Removal of fixed space maintainer	$10.00

RESTORATIVE		**Patient Co-Pay**
D2140	Amalgam – one surface, primary or permanent	$0.00
D2150	Amalgam - two surfaces, primary or permanent	$0.00
D2160	Amalgam - three surfaces, primary or permanent	$0.00
D2161	Amalgam - four or more surfaces, primary or permanent	$0.00
D2330	Resin composite - one surface, anterior	$0.00
D2331	Resin composite - two surfaces, anterior	$0.00
D2332	Resin composite - three surfaces, anterior	$0.00
D2335	Resin composite - four or more surfaces	$0.00
D2390	Resin composite - crown, anterior	No Benefit
D2391	Resin composite - one surface, posterior	Optional
D2392	Resin composite - two surface, posterior	Optional
D2393	Resin composite - three surface, posterior	Optional

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D2394	Resin composite - four or more surface, posterior	Optional

CROWNS		**Patient Co-Pay**
D2510	Inlay - metallic - one surface	Optional
D2520	Inlay - metallic - two surfaces	Optional
D2530	Inlay - metallic - three surfaces	Optional
D2540	Onlay - metallic per tooth	Optional
D2543	Onlay - metallic three surfaces	Optional
D2544	Onlay - metallic four or more surfaces	Optional
D2640	Onlay - Porcelain/ceramic per tooth	Optional
D2740	Crown - porcelain/ceramic substrate	$237.00
D2750	Crown - porcelain fused to high noble metal	$ 238/Optional
D2751	Crown - porcelain fused to predominantly base metal	$212.00
D2752	Crown - porcelain fused to noble metal	$ 229/Optional
D2790	Crown - full cast high noble metal	$ 235/Optional
D2791	Crown - full cast predominantly base metal	$206.00
D2792	Crown - full cast noble metal	$ 224/Optional
D2794	Crown - titanium	Optional
D2799	Provisional crown	$0.00
D2910	Recement inlay	$25.00
D2915	Recement cast or prefabricated post and core	$10.00
D2920	Recement crown	$17.00
D2930	Prefabricated stainless steel crown - primary tooth	$47.00
D2931	Prefabricated stainless steel crown - permanent tooth	$35.00
D2932	Prefabricated resin crown anterior teeth only	$35.00
D2940	Sedative filling	$0.00
D2950	Crown build-up (substructure) including any pins	$35.00
D2951	Pin retention - per tooth, in addition to restoration	$0.00
D2952	Post and core in addition to crown, indirectly fabricated	$49.00
D2953	Each additional indirectly fabricated post - same tooth	$49.00
D2954	Prefabricated post and core in addition to crown	$0.00
D2957	Each additional prefabricated post - same tooth	$0.00
D2970	Temporary crown (fractured tooth)	$10.00
D2971	Additional procedures to construct new crown under existing partial	$36.00
D2980	Crown repair	$20 + lab

ENDODONTICS		**Patient Co-Pay**
D3110	Pulp cap-direct (excluding final restoration)	$0.00
D3120	Pulp cap-indirect (excluding final restoration)	$0.00
D3220	Therapeutic pulpotomy (excluding final restoration)	$0.00
D3221	Gross pulpal debridement, primary and permanent teeth	$0.00
D3230	Pulpal therapy(resorbable filling)-anterior, primary tooth(exclude final restoration)	$0.00
D3240	Pulpal therapy(resorbable filling)- posterior, primary tooth(exclude final restoration)	$0.00
D3310	Root canal therapy - anterior	$100.00
D3320	Root canal therapy - bicuspid	$125.00
D3330	Root canal therapy - molar	$0.00
D3346	Retreatment of previous root canal therapy - anterior	$0.00
D3347	Retreatment of previous root canal therapy - bicuspid	$0.00
D3348	Retreatment of previous root canal therapy - molar	$100.00
D3351	Apexification/recalicifation-initial visit	$0.00
D3352	Apexification/recalcification - interim visit	$0.00
D3353	Apexification/recalcification - final visit	$0.00
D3410	Apicoectomy/periradicular surgery - anterior	$0.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$0.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	$0.00
D3426	Apicoectomy/periradicular surgery - (additional root)	$0.00
D3430	Retrograde filling - per root	$50.00

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PERIODONTICS		Patient Co-Pay
D4210	Gingivectomy or gingivoplasty - Four or more contiguous teeth or bounded teeth spaces per quadrant	$0.00
D4211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	$0.00
D4240	Gingival flap procedure, including root planing - Four or more contiguous teeth or bounded teeth spaces per quadrant	$0.00
D4241	Gingival flap procedure, including root planing - one to three teeth per quadrant	$0.00
D4245	Apically positioned flap	$0.00
D4249	Crown lengthening - hard/soft tissue	$0.00
D4260	Osseous surgery - Four or more contiguous teeth or bounded teeth spaces per quadrant	$0.00
D4261	Osseous surgery - one to three teeth per quadrant	$0.00
D4263	Bone replacement graft - first site in quadrant	$0.00
D4264	Bone replacement graft - each additional site in quadrant	$0.00
D4270	Pedicle soft tissue graft procedure	$0.00
D4271	Free soft tissue graft and donor site	$0.00
D4341	Periodontal root planing - Four or more contiguous teeth or bounded teeth spaces per quadrant	$35.00
D4342	Periodontal root planing - one to three teeth per quadrant	$10.00
D4355	Full Mouth debridement to enable comprehensive evaluation and diagnosis	$0.00
D4381	Site specific therapy	$16.00
D4910	Periodontal maintenance following active therapy	$35.00

PROSTHODONTICS, REMOVABLE		Patient Co-Pay
D5110	Complete denture - Maxillary	$305.00
D5120	Complete denture - Mandibular	$305.00
D5130	Immediate denture - Maxillary	$530.00
D5140	Immediate denture - Mandibular	$530.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$202.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$202.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$331.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$331.00
D5281	Unilateral partial denture	$140.00
D5410	Adjust complete denture - Maxillary	$10.00
D5411	Adjust complete denture - Mandibular	$10.00
D5421	Adjust partial denture - Maxillary	$10.00
D5422	Adjust partial denture - Mandibular	$10.00
D5510	Repair broken complete denture base	$26.00
D5520	Replace missing or broken teeth - complete denture	$24.00
D5610	Repair resin saddle or base	$37.00
D5620	Repair cast framework	$59.00
D5630	Repair or replace broken clasp	$47.00
D5640	Replace broken teeth - per tooth	$32.00
D5650	Add tooth to existing partial denture	$42.00
D5660	Add clasp to existing partial denture	$47.00
D5670	Replace teeth and acrylic on cast metal framework (mandibular)	$165.00
D5671	Replace teeth and acrylic on cast metal framework (maxillary)	$165.00
D5710	Rebase denture - complete, Maxillary	$121.00
D5711	Rebase denture - complete, Mandibular	$121.00
D5720	Rebase denture - partial, Maxillary	$162.00
D5721	Rebase denture - partial, Mandibular	$162.00
D5730	Reline denture - complete Maxillary (chairside)	$57.00

Sound Health & Wellness Trust

Sound Plan– DELTACARE PROGRAM #00405

Code	Description	Patient Co-Pay
D5731	Reline denture - complete Mandibular (chairside)	$57.00
D5740	Reline denture - partial Maxillary (chairside)	$55.00
D5741	Reline denture - partial Mandibular (chairside)	$55.00
D5750	Reline denture - complete Maxillary (laboratory)	$100.00
D5751	Reline denture - complete Mandibular (laboratory)	$100.00
D5760	Reline denture - partial Maxillary (laboratory)	$96.00
D5761	Reline denture - partial Mandibular (laboratory)	$96.00
D5820	Temp partial stay plate, Maxillary	No Benefit
D5821	Temp partial stay plate, Mandibular	No Benefit
D5850	Tissue conditioning, Maxillary - denture	$10.00
D5851	Tissue conditioning, Mandibular - denture	$10.00
D5860	Overdenture - complete by report	$314.00
D5861	Overdenture - partial by report **Includes any adjustments for 6 months	$342.00

PROSTHODONTICS, FIXED		**Patient Co-Pay**
D6210	Pontic - cast high noble metal	Optional
D6211	Pontic - cast predominantly base metal	$202.00
D6212	Pontic - cast noble metal	Optional
D6240	Pontic - porcelain fused to high noble metal	Optional
D6241	Pontic - porcelain fused to predominantly base metal	$212.00
D6242	Pontic - porcelain fused to noble metal	Optional
D6250	Pontic - resin with high noble metal	Optional
D6251	Pontic - resin with predominantly base metal	$70.00
D6252	Pontic - resin with noble metal	Optional
D6600	Inlay - porcelain/ceramic, two surfaces	Optional
D6601	Inlay - porcelain/ceramic, three or more surfaces	Optional
D6602	Cast high noble metal, two surfaces	Optional
D6603	Inlay - cast high noble metal, three or more surfaces	Optional
D6604	Inlay - cast predominantly base metal, two surfaces	Optional
D6605	Inlay - cast predominantly base metal, three or more surfaces	Optional
D6606	Inlay - cast noble metal, two surfaces	Optional
D6607	Inlay - cast noble metal, three or more surfaces	Optional
D6608	Onlay - porcelain/ceramic, two surfaces	Optional
D6609	Onlay - porcelain/ceramic, three or more surfaces	Optional
D6610	Onlay - cast high noble metal, two surfaces	Optional
D6611	Onlay - cast high noble metal, three or more surfaces	Optional
D6612	Onlay - cast predominantly base metal, two surfaces	Optional
D6613	Onlay - cast predominantly base metal, three or more surfaces	Optional
D6614	Onlay - cast noble metal, two surfaces	Optional
D6615	Onlay - cast noble metal, three or more surfaces	Optional
D6616	Retainer - cast metal for resin bonded fixed prosthesis	Optional
D6720	Crown - resin fused to high noble metal	No Benefit
D6721	Crown - resin with predominantly base metal	No Benefit
D6722	Crown - resin with noble metal	No Benefit
D6750	Crown - porcelain fused to high noble metal	Optional
D6751	Crown - porcelain fused to predominantly base metal	$213.00
D6752	Crown - porcelain fused to noble metal	Optional
D6780	Crown - 3/4 cast high noble metal	Optional
D6790	Crown - full cast high noble metal	Optional
D6791	Crown - full cast predominantly base metal	$208.00
D6792	Crown - full cast noble metal	Optional
D6930	Recement bridge	$27.00
D6940	Stress breaker	$61.00
D6970	Post and core in addition to bridge retainer, indirectly fabricated	$21.00
D6972	Prefabricated post and core buildup	$44.00
D6973	Core buildup for retainer, including any pins	$26.00

Sound Health & Wellness Trust

Sound Plan– DELTACARE PROGRAM #00405

Code	Description	Patient Co-Pay
D6976	Additional indirectly fabricated post - same tooth	$26.00
D6977	Each additional pre-fabricated post - same tooth	$26.00

ORAL SURGERY		Patient Co-Pay
D7111	Extraction, coronal remnants - decidious tooth	$20.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$30.00
D7210	Surgical removal of erupted tooth	$0.00
D7220	Removal of impacted tooth - soft tissue	$0.00
D7230	Removal of impacted tooth - partially bony	$0.00
D7240	Removal of impacted tooth - completely bony	$0.00
D7241	Removal of impacted tooth - completely bony with unusual surgical complications	$0.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$0.00
D7286	Biopsy of oral tissue, soft	$0.00
D7310	Alveoloplasty in conjunction with extraction four or more teeth or tooth spaces per quadrant	$0.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extraction four or more teeth or tooth spaces per quadrant	$0.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	
D7340	Vestibuloplasty	$0.00
D7350	Vestibuloplasty - ridge extension	$0.00
D7471	Removal of lateral exostosis -(maxilla or mandible)	$0.00
D7472	Removal of torus palatinus	$0.00
D7473	Removal of torus mandibularis	$0.00
D7510	Incision and drainage of abscess	$0.00
D7960	Frenulectomy (frenectomy or frenotomy)	$0.00
D7970	Exc of hyperplastic tissue - per arch	$13.00

ADJUNCTIVE GENERAL SERVICES		Patient Co-Pay
D9110	Palliative treatment	$10.00
D9220	General anesthesia: up to 30 minutes	No Benefit
D9221	General anesthesia: each additional 15 minutes	No Benefit
D9230	Analgesia,anxiolysis, inhalation of nitrous oxide	No Benefit
D9241	Intravenous sedation/analgesia up to 30 minutes	No Benefit
D9242	Intravenous sedation/analgesia each additional 15 minutes	No Benefit
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9910	Application of desensitizing medications	No Benefit
D9940	Occlusal Guards by report	$20.00
D9951	Occlusal adjustment - limited	$0.00
D9952	Occlusal adjustment - complete	No Benefit
D9969	Broken appointment fee (per 15 minutes of scheduled appointment time)	$10.00

Sound Plan – SCHEDULE PLAN PROGRAM #09393

Sound Health & Wellness Trust
Dental Schedule of Allowances

If the procedure performed is not shown in this Schedule and is not expressly excluded by any of the terms of this Plan, a procedure of equivalent gravity and severity may be used as a basis for determining the maximum allowance. The final determination of allowances, if any, is within the sole discretion of the Trust. These allowances apply to claims incurred on or after October 1, 2007. The ADA codes as listed may have changed or are subject to change.

ADA Code	Procedure	Maximum Benefit Allowance
Diagnostic		
	Exams	
0120	Periodic oral exam	$34.00
0140	Limited, problem-focused oral exam	$46.70
0150	Comprehensive/initial oral exam	$54.10
	Radiographs (X-rays)	
	Complete mouth	
0210	* Intraoral (including bitewings)	$82.30
0330	* Panoramic	$71.70
	Intraoral periapical	
0220	* First film	$17.60
0230	* Each additional film	$16.30
	Bitewings	
0270	* Single film	$17.60
0272	* 2 films	$27.80
0274	* 3 to 4 films	$39.40
0240	Occlusal single film	$27.00
0340	Cephalometric (other than TMJ or orthodontia)	$82.20
0470	Study models	$68.30
Preventive		
	Prophylaxis (cleaning and scaling)	
1110	* Age 14 and over (adult)	$69.40
1120	* To age 14 (child)	$44.40
	Fluoride Application (excluding prophylaxis)	
1204	* Age 14 and over (adult)	$24.50
1203	* To age 14 (child)	$26.40
1351	Sealant, each tooth	$34.10
Minor Restorations		
	Amalgam Restorations	
2140	Primary, permanent - 1 surface	$79.00
2150	Primary, permanent - 2 surfaces	$107.70
2160	Primary, permanent - 3 surfaces	$132.90
2161	Primary, permanent - 4 or more surfaces	$159.20
	Other Minor Restorations	
2330	Composite resin - 1 surface, anterior	$96.10
2331	Composite resin - 2 surfaces, anterior	$125.70
2332	Composite resin - 3 surfaces, anterior	$158.10
2335	Composite resin - 4 or more surfaces, anterior	$184.80
Major Restorations (predetermination required)		
	Inlays/Onlays	
2510	Inlay-gold - 1 surface	$356.00
2520	Inlay-gold - 2 surfaces	$396.90
2530	Inlay-gold - 3 or more surfaces	$425.30
2542	Onlay-gold - 2 surfaces	$401.10
2543	Onlay-gold - 3 or more surfaces	$438.90
2910	Recement inlay/onlay	$49.70
	Crowns	
2740	Porcelain	$435.80
2750	Porcelain with metal (gold)	$435.80
2780	Gold (3/4 cast)	$435.80
2790	Gold (full cast)	$435.80
2930	Stainless steel, primary	$107.10
2931	Stainless steel, permanent	$136.50
	Other Services	
2910	Recement inlay	$49.70
2920	Recement crown	$62.20
2940	Sedative filling/temporary crown (fractured tooth)	$65.10
2950	Core buildup, including any pins	$133.40
2951	Pin retention - each tooth	$27.30
2952	Cast post/core	$174.30
Endodontics		
	Pulp Treatment	
3110	Pulp cap	$52.50
3220	Vital pulpotomy	$121.80
	Root Canal Therapy (includes treatment plan, clinical procedures and follow-up care; excludes final restoration)	
3310	1 root	$427.40
3320	2 roots	$528.70
3330	3 or more roots	$747.30
3410	Apicoectomy (performed as a separate surgical	$588.10

Sound Health & Wellness Trust
Dental Schedule of Allowances

Code	Procedure	Allowance
	procedure, including curettage) - first root, anterior	
3421	Apicoectomy (performed as a separate surgical procedure, including curettage) - first root, bicuspid	$690.90
3425	Apicoectomy (performed as a separate surgical procedure, including curettage) - first root, molar	$634.20
3426	Apicoectomy (performed as a separate surgical procedure, including curettage) - each additional root	$246.80
3430	Retrograde filling, each root	$176.40
3450	Root amputation, each root	$335.90
Periodontics		
9310	Periodontal exam	$86.40
4910	Periodontal maintenance (prophylaxis)	$113.60
4210	Gingivectomy - each quadrant	$420.00
4211	Gingivectomy - each tooth	$149.10
4260	Osseous surgery - each quadrant	$908.40
4271	Free soft tissue grafts - each site	$529.20
Oral Surgery		
	Extractions (includes local anesthesia and routine postoperative care)	
7111	Extraction, coronal remnants - decidous tooth	$90.80
7140	Extraction, erupted tooth or exposed root	$90.80
7210	Erupted tooth (surgically removed)	$178.70
7240	Impacted tooth - completely bony	$320.30
7250	Surgical removal of roots	$196.40
	Related Oral Surgical Procedures	
7270	Reimplantation of tooth	$315.00
7286	Biopsy of oral tissue (soft)	$211.10
7310	Alveoloplasty - each quadrant	$188.00
7471	Removal of exostosis - each site	$377.00
7510	Incision and drainage of abscess (intraoral)	$147.00
7960	Frenulectomy (separate procedure)	$284.10
Prosthodontics (predetermination required)		
	Dentures	
5110	Complete upper or lower	$661.50
5211	Partial upper or lower - resin base (including conventional clasps, rests and teeth)	$404.30
5213	Partial upper or lower - cast base (including conventional clasps, rests and teeth)	$682.50
5410	Denture adjustment	$39.90
5610	Repair broken denture (no teeth involved)	$87.40
5640	Replace broken tooth	$83.10
5650	Add tooth to denture	$102.10
5710	Denture rebase	$283.50
5750	Reline denture	$286.20

Code	Procedure	Allowance
	Dental Implants	
6010	Each implant	$869.40
	Maximum - each arch	$1,738.80
	Lifetime maximum	$3,477.60
	Bridgework	
6210	Cast gold pontic	$420.00
6240	Porcelain - fused to gold pontic	$420.00
6545	Retainer - cast metal for resin-bonded fixed prosthesis	$262.50
6750	Porcelain - fused to gold abutment crown	$430.50
6790	Cast gold abutment crown	$430.50
6930	Recement bridge	$92.10
	Other Dental Procedures	
9110	Emergency care for pain	$83.50
9220	General anesthesia*	$320.30
9241	Intravenous conscious sedation/analgesia - first 30 minutes	$107.50
9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$55.40
9310	Professional consultation	$86.40
	Space Maintainers	
1510	Fixed space maintainer (fixed, unilateral)	$212.10
1515	Fixed space maintainer (fixed, bilateral)	$305.60
9940	Night guard	$408.50
	TMJ/TMD Therapy	
9310	Exam	$86.40
0330	X-rays	$71.70
0470	Models	$68.30
7880	Device/appliance	$408.50
	Appliance adjustment (maximum of 4)	$39.90
9951	Occlusal adjustment (limited; maximum of 4)	$84.00
9952	Occlusal adjustment (complete)	$378.00

*** Dentally necessary general anesthesia provided in an appropriate outpatient ambulatory facility is covered at 80% of UCR.**

Sound Health & Wellness Trust

Sound Plan – Schedule Plan of Allowances

EXCLUSIONS

No benefits are provided for the following:

1. Care for any dental condition, ailment, or injury for which you or your dependent are entitled to receive benefits in whole or in part under occupational coverage voluntarily obtained by the employer or required by Workers' Compensation of the United States or services rendered in a hospital owned or operated by a State or United States Government Agency or any care for which benefits are available under any State or Federal Act, even though the member and/or their dependent waives their right to such benefit.

2. Charges in excess of the maximum allowance for the procedure.

3. Expenses incurred before the patient becomes eligible, including charges for prosthodontic devices and crowns prepared before the effective date but placed after the effective date.

4. Services performed for cosmetic purposes, unless the procedure is performed as part of treatment of a covered functional disorder or as a result of an accidental injury.

5. Prescription drugs.

6. Replacement of dentures (full or partial) and bridges more often than once in each five-year period.

7. Charges made after termination of coverage, except:

    - required pre-determined services received within 30 days after termination of dental coverage (provided the request for required predetermination of benefits was received at the Trust Office while eligible), or
    - prosthodontic devices that are ordered prior to termination and delivered within 30 days after termination of dental coverage.

8. Use of Nitrous Oxide.

9. Replacement of a prosthodontic device or orthodontic appliance that is lost, stolen or damaged by neglect.

10. Oral examination or prophylaxis (cleaning of teeth) more often than twice in a calendar year.

11. Payment for full-mouth x-rays or fluoride treatments more than once each calendar year.

12. Dental procedures not recommended and approved by a dentist.

13. Services for which no charge is made, or which would not have been made in the absence of the benefits provided by this Plan.

14. Conditions caused by or arising out of an act of war, armed invasion or aggression.

15. Separate asepsis or sterilization charges.

16. Charges for precision attachments.

17. Charges for duplicate dentures.

18. Hospital charges for treatment of a dental condition.

19. Charges for completion of claim forms, missed appointments, telephone consultations or other consultation when a dentist does not physically see a patient.

20. Charges for services or supplies provided by a dentist, denturist or dental hygienist who usually lives in your home or is related by blood or marriage.

21. Charges for orthodontia or orthodontic retainer adjustment.

22. Charge when the patient has not actually received service, for example, a crown that is ordered but is not placed.

23. Expenses incurred from any attempt at suicide or from an intentionally self-inflicted injury or illness.

24. Dental services and supplies that are determined to be Experimental and/or Investigational.

25. Charges for home use supplies, such as toothpaste, toothbrush, water-pick, fluoride, mouthwash, dental floss, etc.

26. Oral hygiene and/or dietary instruction or for a plaque control program (a series of instructions on the care of the teeth).

27. Services provided primarily for the convenience of the patient or the provider.

28. Treatment, other than the scheduled benefits, of jaw joint problems including temporomandibular joint (TMJ) dysfunction, disorder, or syndrome, and any other craniomandibular disorders or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues relating to that joint.

29. If a patient seeks care from more than one dentist during the course of any treatment, or if more than one dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable from one dentist. Nor will the Plan be liable for duplication of services.

30. No benefits will be issued for claims received after the 12-month filing limitation.

IMPORTANT NUMBERS

Eligibility, Enrollment Process

(206) 282-4500 or (800) 225-7620

Schedule Plan or WDS Preferred Dental Plan

(800) 554-1907

WDS DeltaCare Plan

(800) 650-1583