Dental Plan

EXCELLUS BLUECROSS BLUESHIELD ("EXCELLUS") ■ PLAN MANAGER
165 COURT STREET, ROCHESTER, NY 14647
1-800-499-1275

INTRODUCTION

The Rochester City School District Dental Plan ("Plan") is designed to encourage good dental health for employees and their family members while helping them meet the expenses of quality dental care. Regular check-ups (at least once every year) and prompt treatment of small problems when they are first discovered combine to help prevent more serious problems from developing later.

The Plan allows employees and their dependents complete freedom in the choice of a dentist, and the Plan places virtually no restriction on the dentist as to the type of care or treatment undertaken to assure the patient's dental health. However, the Plan will only pay benefits for dental services as outlined in this booklet.

For you, the employee, and for your dependents, there are no preliminary dental examination requirements to establish eligibility. For your dentist, there is a minimum of paperwork.

If you have any questions about your Plan after reading this booklet, please contact the Rochester City School District Employee Benefits Department or Excellus.

ELIGIBILITY

Employees are entitled to enroll in the dental Plan effective the first day of full-time employment. Enrollments must be completed within 30 days of employment or qualifying event.

Your dependents are also eligible as follows:

- Your spouse.
- Your unmarried children, including stepchildren and legally adopted children and children who have been placed under your legal guardianship, until the end of the calendar year that they reach their 23rd birthday, or until the end of the calendar year that they reach their 26th birthday if they are full-time students. Orthodontic benefits are provided for unmarried dependent children to age 19.

Unmarried children will continue to be covered after age 23 if incapable of self-sustaining employment by reason of mental or physical handicap, with supporting documentation.

No person may be covered by the Plan as both an employee and a dependent nor as the dependent of more than one person.

YOUR DENTIST

You and your eligible dependents have free choice of any legally practicing dentist. In cases of dispute, RCSD will rely on the findings of Excellus's dental advisor and upon applicable peer review organizations.

Because dentists who participate in the Excellus Preferred Provider Network have agreed to accept plan payments as payment in full, it may be to your advantage to choose one of these dentists. Further, because dentists who are listed in the Excellus network have agreed to charge not more than Rochester-area average fees, it may be to your advantage to choose one of these dentists.

Most dentists look upon dental plans with favor because they know these plans encourage good dentistry. You should discuss your Plan with your dentist and go over points in this descriptive booklet. Ask for clarification as necessary. This will help you understand your Plan and how it can assist you to reach and maintain good oral health.

DEFINITIONS

Dentist – A dentist is an individual licensed to practice dentistry and/or to perform oral surgery. A licensed physician who performs dental services within the scope of a medical license will also be considered to be a dentist for the purposes of this Plan.

Covered Dental Expenses -- The expenses incurred by or on behalf of any employee or dependent for charges made by a dentist for necessary services covered by the Plan while the patient is eligible for Plan benefits.

Member – Any employee or eligible dependent who meets all applicable eligibility requirements, for whom the required premium payment has actually been received, and who is covered under the Plan.

Schedule of Allowances – The amount paid or reimbursed by the Plan for each covered service. If the dentist charges an amount that is more than the Plan allowance, the balance is owed by the patient.

SERVICES & PLAN BENEFITS

COVERED DENTAL SERVICES

Your Plan covers almost all dental services which are essential for care of the teeth. There is an Annual Maximum Benefit for all services other than Orthodontics and a Lifetime Maximum Benefit for Orthodontic services. See the Summary of Benefits at Appendix B. Dental services covered by the Plan include but are not limited to the following:

DIAGNOSTIC AND PREVENTIVE SERVICES

Clinical Oral Examinations. The Plan will provide coverage for an oral examination twice in any calendar year. The Plan will also provide coverage for emergency oral examinations to treat pain; if an operative procedure is also provided on the same day, coverage for the emergency oral exam is included in the payment for the operative procedure.

Dental Prophylaxis, including Cleaning, Scaling and Polishing. The Plan will provided coverage for prophylaxis twice in any calendar year. The Plan will provide coverage for cleaning or scaling of teeth performed by a licensed dental hygienist if such treatment is rendered under the supervision and direction of a dentist.

Radiographs. Full Mouth or Panoramic. The Plan will provide coverage for the following complete intra-oral x-rays once every 36 consecutive months; a complete series of bitewings (16 films); or a panoramic film. The Plan will not provide coverage for periapical x-rays when performed on the same date as a complete series or a panoramic x-ray. When the total amount charged for individual periapical x-rays equals or exceeds the Schedule of Allowances for a complete series, benefits are limited to the Schedule of Allowances for a complete series.

Bitewings. The Plan will provide coverage for up to a combination of four bitewing films in a calendar year. The Plan will not provide coverage for bitewings provided in conjunction with a full mouth series.

Diagnostic Radiographs and Photographs. The Plan will provide coverage for diagnostic x-rays and photographs. The Plan will only provide coverage for photographs once in a calendar year.

Facial Images. The Plan will provide coverage for facial images once in a calendar year.

Topical fluoride application for individuals to age 19, covered twice per calendar year.

Palliative Emergency Treatment. The Plan will provide coverage for emergency care you receive from a dentist that is designed only to relieve your dental pain until corrective treatment can be provided.

Sealants. The Plan will provide coverage for the topical application of sealants on un-restored, permanent molars once in any 36 consecutive months for Members to age 19 years of age.

Space maintainers for individuals to age 19
- Unilateral
- Bilateral
- Athletic mouth guards (for dependents to age 19)

BASIC RESTORATIVE SERVICES

Amalgam and Composite Restorations. The Plan will provide coverage for amalgam and composite restorations for treatment of cavities. Restorations including multiple surfaces will, for the purpose of providing benefits, be combined; and benefits will be provided according to the number of surfaces treated. Benefits for each surface are allowed once in 12 consecutive months.

Reinforcement pins (per tooth)

Oral Surgery. The Plan will provide coverage for oral surgery, consisting of; surgical extractions, including removal of impacted teeth; odontogenic cysts, lesions and biopsies; tooth re-implantation; tooth transplantation and alveoplasty. Coverage for local anesthesia, routine pre and post operative procedures, sutures and suture removal are included in our Schedule of Allowances for the surgery; and the Plan will not provide additional benefits for such services. Benefits for extraction of impacted wisdom teeth include coverage for IV sedation.

Miscellaneous Services

General Anesthesia, in hospital, each 15 minutes
Consultations
In-hospital visit

Endodontics

Pulpotomy, therapeutic
Root Canal Therapy
- Anterior
- Bicuspid
- Molar

Apiceotomy

Anterior
Bicuspid
Molar
Each additional root
Hemisection

Periodontics

Gingivectomy or gingivoplasty, per quadrant, covered once per quadrant every three years

Osseous surgery, per quadrant, covered once per quadrant every three years

Bone replacement graft, per quadrant, covered once per quadrant every three years

Soft tissue grafts, per quadrant, covered once per quadrant every three years

Peridontal scaling, per visit, maximum of 5 visits covered per year.

MAJOR RESTORATIVE SERVICES

Inlays: Metallic, Porcelain, or Composite, covered once per tooth every five years
Two surfaces
Three surfaces or more

Inlays/Onlays and/or Crowns. The Plan will provide coverage for inlays/onlays and/or crowns only when teeth cannot be restored by a filling. Our coverage for these restorations includes all necessary: bases; pulp medications; liners; gingival preparation; impressions; temporary crowns; finishing; and occlusal adjustments.

The following benefit limitations apply:

(1) When an inlay/onlay or crown is used to replace an existing filling in the absence of decay, the Plan will only provide benefits that are based on the Schedule of Allowances for an amalgam or composite filling. When an inlay/onlay or crown is not used to replace an existing filling, the Plan will only provide benefits for an inlay/onlay or crown that is medically necessary to treat a tooth due to severe decay and/or fracture.

(2) The Plan will only provide benefits for the replacement of an inlay/onlay or crown with another inlay/onlay or crown if more than five years have elapsed since the last placement.

(3) The Plan will only provide coverage for plastic or stainless steel crowns for Members to age 19.

(4) The Plan will only provide benefits for re-cementation that is performed more than six months after the initial insertion.

(5) The Plan will not provide benefits for an inlay/onlay or crown or the fitting thereof: that was ordered while the Member was not covered under the Plan; or that was ordered while the Member was covered under the Plan, but finally installed more than 30 days after termination of coverage under this Plan.

Removable and Fixed Prosthodontics. Benefits will be provided for the following removable and fixed prosthodontics: full and partial dentures; and fixed bridgework. The following limitations apply:

(1) The Plan will only provide benefits for the replacement of a denture, partial denture or fixed bridgework for which benefits were provided under this Plan with another denture, partial denture or fixed bridge: when the existing prosthetic was placed more than five years ago; and cannot be made serviceable.

Benefits for the upgrading from a partial denture to fixed bridgework are limited to the Schedule of Allowances for a partial denture.

Benefits for replacement of bilateral or multiple missing teeth in the same arch are limited to the Schedule of Allowances for the partial denture.

(2) The Plan will not provide coverage for denture replacement made necessary by reason of loss or theft.

(3) The Plan will only provide benefits for adjustments, re-cementation or repairs to full or partial dentures or bridges when the adjustment, re-cementation or repair is performed more than six months after the initial insertion of the prosthesis.

(4) Benefits for denture reline or rebases are limited to one in a 36-month period and must occur at least six months after initial placement.

(5) Benefits for temporary partial stayplate dentures (flipper) are limited to the replacement of extracted anterior teeth.

(6) Benefits for the following are included in the Schedule of Allowances for the major procedure: tooth preparation; temporary bridges; bases; impressions; anesthesia; preparation of the gingival tissue; or other services that are components of a complete procedure.

(7) Removal of part of a root (hemisection) does not qualify as a tooth extraction when determining benefits in connection with installation of removable or fixed prosthetics.

(8) A bridge in conjunction with a partial denture in the same arch is considered optional and benefits are limited to the Schedule of Allowances for a partial denture.

(9) The following in connection with a denture, partial denture or bridge are limited to the Schedule of Allowances for a standard procedure: precision or semi-precision attachments; athletic mouth guards; special techniques or personalized restoration.

(10) The Plan will not provide benefits for a denture, partial denture or bridge of the fitting thereof: that was ordered while the Member was not covered under this Plan; or that was ordered while the Member was covered under this Plan, but finally installed or delivered to such Member more than 30 days after termination of coverage under this Plan.

DENTURE REPAIRS

5130 Immediate denture - maxillary Includes all adjustments, relines and tissue conditioning within six months.

5140 Immediate denture - mandibular Includes all adjustments, relines and tissue conditioning within six months.

If prosthetic is a replacement, indicate date of original placement and reason for replacement. Replacement of a partial denture with another prosthetic is only covered if more than 5 years has lapsed since last placement and it cannot be repaired. No additional benefits for precision or semi-precision attachments. Allowance includes clasps and rests, all teeth, all impressions, try-ins, and adjustments and repairs within 6 months of placement. Radiographs required upon request. **Charges for the replacement of a lost or stolen prosthetic is not covered.** The date of service is the date the permanent prosthetic is delivered to the patient.

REPAIRS TO COMPLETE DENTURES
Limited to repairs to removable prostheses performed more than 6 months after the insertion.
5520 Replace missing or broken teeth - complete denture (each tooth)
Limited to a maximum of two teeth per arch.(this is to make sure all the teeth are not replaced at one time. That can cost more than the denture itself)

Limited to repairs to removable prostheses performed more than 6 months after the insertion.
5610 Repair resin denture base III 10.0
5620 Repair cast framework III SC Narrative required. Subject to consultant review.
5630 Repair or replace broken clasp. Limited to two per arch.
5640 Replace broken teeth - per tooth Limited to two per arch.
5650 Add tooth to existing partial Denture. Limited to a maximum of two teeth per arch, per episode.
5660 Add clasp to existing partial denture. Limited to two per arch.

DENTURE RELINE PROCEDURES
Limited to relining done more than 6 months after initial insertion, then not more than one in 36 consecutive months.

5850 Tissue conditioning, maxillary Allowed once in 3 years.
5851 Tissue conditioning, mandibular Allowed once in 3 years.

Waiting periods- RCSD does not have a waiting period.

Other Prosthetic Services, covered once every five years

Obturator
Add new tooth to denture
Add clasp to denture
Reline, Rebase, jumps
Duplicating denture, jump, partial
Reline/Rebase full denture, chairside or laboratory
Reline/Rebase partial denture, chairside or laboratory

Fixed Bridges, covered once every five years

<u>Crowns as abutments</u>

Resin with Base metal
Porcelain veneer Base metal
3/4 cast High Noble metal
Full cast Base metal

<u>Pontics</u>

Cast base metal
Porcelain fused to base metal

Recement bridge
Bridge repairs

Replacement of Crowns, Inlays/Onlays, and Fixed Bridges are covered once every 5 years.

ORTHODONTICS, limited to unmarried dependent children to age 19, up to the Lifetime Maximum

Diagnosis and Appliance Insertion
Preliminary appliances
Active treatment
Passive treatment

ANNUAL MAXIMUM BENEFIT AMOUNT

The plan will pay an Annual Maximum Benefit Amount per person per calendar year for covered services other than Orthodontics. See the Summary of Benefits at Appendix B.

LIFETIME MAXIMUM ORTHODONTIC BENEFIT AMOUNT

For unmarried dependent children to age 19, the plan will pay a Lifetime Maximum Orthodontic Benefit Amount per person. See the Summary of Benefits at Appendix B.

NOTE: With few additions, procedure numbers and descriptions of covered services are as published in the current American Dental Association, CDT code on dental procedures and nomenclature. Any differences in wordings are for clarity and space considerations. Questions should be directed to the Plan Manager: Excellus

BENEFITS FOR COVERED DENTAL SERVICES

The Plan will pay paid-in-full benefits for covered dental services when provided by a dentist who is in the Excellus Preferred Provider Network. Dentists in this network agree to accept the Excellus Schedule of Allowances as complete payment for covered services that they provide (see Appendix A for Excellus Fee Schedule). Any amounts billed that are in excess of one of the plan maximum amounts will not be paid by the Plan.

If you choose to obtain services from a dentist who is not in the Excellus Preferred Provider Network, the Plan will pay for all covered services according to the "non-participating Schedule of Allowances" 90th of UCR (see below for explanation of Usual and Customary Charge). You will be responsible for paying the dentist amounts billed that are more than the Schedule amounts. However, the non-participating provider should not bill you more than the 90th of UCR. Any amounts billed that are more than the Schedule amounts are not counted toward the Annual and Lifetime Maximum Benefits.

In no event will this Plan pay more than the Usual and Customary Charge for dental care (e.g., service, device, procedure, supply, drug, etc.) The Usual and Customary charge is the average amount charged for the care by the majority of dentists in the geographic area for care delivered in that geographic area or, if less, the amount actually billed. In arriving at the average charge, the Plan will consider amounts billed to governmental payors (e.g. Medicare and Medicaid), non-governmental contracted payors (e.g. Blue Cross and Blue Shield contracted rates), and non-contracted payors. The

Plan Manager has the discretionary authority to decide whether a charge is a Usual and Customary Charge.

PRE-TREATMENT ESTIMATES

If expenses for a dental service or a series of services are expected to be $300.00 or more, the patient should ask the dentist to submit a statement of planned treatment to Excellus for review. The dental claim form is available at www.excellusbcbs.com. Excellus will tell the dentist the amount of benefits payable by the Plan for the work indicated.

Whether or not a pre-treatment estimate is requested, the amount of expenses included as Covered Dental Expenses will be determined by Excellus taking into account alternate procedures, services, or courses of treatment based upon professionally endorsed standards of dental care.

CLAIMS ADMINISTRATION

Following treatment by a dentist, in most instances the dental office will submit a claim form – usually in electronic form – to Excellus. Many dentists who are not in one of the networks recognized by your Plan will submit claim forms on your behalf if you ask them to do so. In some cases the dentist will not do this, and you will have to complete and submit the claim form yourself, available at www.excellusbcbs.com. If you need help doing this, please contact Excellus.

RCSD, through Excellus reserves a right to deny payment relative to any claim form received by Excellus beyond one year of date of service. Plan Years and Benefit Years are January 1 through December 31.

COORDINATION OF BENEFITS

If you or your family members are eligible to receive benefits under another group plan, benefits from this Plan will be coordinated with the benefits from any of your other group plans so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid by the plans.

An "allowable expense" is any necessary, usual, customary, and reasonable expense covered in full or in part under any one of the group plans involved.

A "plan" is considered to be any group insurance coverage or other arrangement of coverage for individuals in a group which provides medical or dental benefits or services on an insured or an uninsured basis.

If a family is covered by another plan, claims should first be submitted to the plan most closely associated with the patient. Each spouse should first submit a claim to his or her own employer's plan. Claims for dependent children will be covered first by the parent whose birthday (month and day, not year) comes first in the calendar year.

In order to obtain all of the benefits available, you and your family members should file claims under each plan. Excellus reserves the right to obtain and exchange benefit information from any insurance company, organization, or individual to determine the applicability of the Coordination of Benefit provisions. Should an overpayment be made, Excellus has the right to recover the excess payment from the individual, insurance company, or organization to which the payment has been made.

LIMITATIONS AND EXCLUSIONS

1. Orthodontic benefits are provided only for unmarried dependent children to age 19.
2. Orthodontic services will be deemed rendered on the date performed.
3. Prophylaxis (cleaning) is limited to 2 per calendar year.
4. Examinations are limited to 2 per calendar year.
5. Fluoride Treatment is limited to 2 per calendar year and only for dependents to age 19.
6. Space Maintainers are covered only for dependents to age 19.
7. Complete series and panorex x-rays are limited to once (either complete series or panorex, not both) in a three-year period.

8. Bitewing x-rays are limited to a maximum of 4 films per calendar year.

9. Periodontal scaling, periodontal prophylaxis, and ordinary prophylaxis, combined, are limited to 5 treatments per year.

10. Periodontal surgery is covered once every three years per quadrant.

11. Insertion of Prosthetic services (dentures, crowns, bridges) includes 12 months post-delivery care.

12. Duplication (jump), rebase, or relines to a denture are limited to one per denture, per five year period.

13. Overlay full dentures are paid for at the fee for full dentures. There is no payment for treatment of an abutment tooth or attachment tooth.

14. When a fixed bridge and partial denture are inserted in the same jaw, only the partial denture is a covered service.

15. Replacement of full and partial dentures are covered once every 5 years.

16. Replacement of Crowns, Inlays/Onlays, and Fixed Bridges are covered once every 5 years.

17. Veneer crowns on lower molars and second and third upper molars are paid as full cast crowns only.

18. When a more costly material or service is substituted for a less costly material or service having the same function, the Plan will pay the allowance for the less costly item.

19. Reimbursement for temporary services is considered part of the completed service allowance.

20. You are not covered for implants. You are not covered for crowns or pontics over implants.

21. You are not covered for crowns or pontics for attachment or clasp purposes, unless that tooth is so broken down that it cannot be restored properly by filling. A cantilever pontic, when used for attachment reasons for a partial in the same jaw, is not covered.

22. Double and multiple abutments are not covered.

23. Fixed and removable splints, except when a missing tooth is being replaced, are not covered. Only that portion of the splint replacing the missing tooth is covered. Splints using enamelate or similar material are not covered.

24. The rebase or repair of newly inserted dentures is not covered for the first six months following insertion.

25. Appliances used solely as an adjunct to periodontal care or temporomandibular joint dysfunction is not covered.

26. Expenses for items such as gloves, masks, and other items and services required to comply with Federal and State environmental or public health laws and regulations are not covered.

27. Temporary appliances are not covered.

28. Expenses for services and supplies that are partially or wholly cosmetic in nature are not covered.

GENERAL LIMITATIONS

No payment will be made under the Plan for expenses incurred by an employee or a dependent:

- For, or in connection with, an injury arising out of, or in the course of, any employment for wage or profit;
- For, or in connection with, a sickness for which the employee or dependent is entitled to benefits under any Workers' Compensation or similar law;
- In a hospital owned or operated by the United States Government, unless there is legal obligation to pay such charges without regard to the existence of any insurance plan;
- To the extent that payment under this policy is prohibited by any law of the jurisdiction in which the employee or dependent resides at the time the expenses are incurred;
- For charges which the employee or dependent is not legally required to pay or for charges which would not have been made if no coverage had existed (for example, charges for completion of a claim form);
- For charges made which are in excess of the applicable Schedule of Allowances or for charges for unnecessary care or treatment;
- To the extent that the employee or dependent is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any public program other than the program of Medical Assistance for Needy Persons established by the State of the employee or dependent's residence under the provisions of Title XIX of the Social Security Act of 1965 as amended. For the purposes of this paragraph, any individual who, at any time, was entitled to enroll in all or any portion of the Medicare program but who did not so enroll will be considered to be entitled to reimbursement in any amount equal to the amount to which he would have been entitled, if any, if he or she were so enrolled.

TERMINATION OF BENEFITS

Your eligibility to participate in the Plan will cease at the end of the month in which you are separated from active service with your employer. In the event of your death, your dependents' coverage will terminate on the last day of the month in which your death occurs.

If you are placed on leave without pay status, you may be eligible to continue your coverage.
Payments of the full cost of coverage for this period must be made directly to the Rochester City School District through your employee benefit office.

COBRA
(Consolidated Omnibus Budget Reconciliation Act of 1985)

If you, and/or your covered dependent(s) are not covered under another employer-sponsored group dental plan, immediately following termination of eligibility for this Plan, you and they have some important rights concerning the continuation of your group dental benefits, if the coverage should terminate because of certain events.

Listed below are the events that could cause you, and/or covered dependent(s) to lose group dental coverage and the length of time coverage can be continued if one of these events occurs.

	EVENT	LENGTH OF TIME COVERAGE CAN BE CONTINUED
1.	Employee terminates employment (except for gross misconduct)	18 months
2.	Employee terminates employment due to a disability	18 months*
3.	Employee's hours are reduced	18 months
4.	Employee dies	36 months
5.	Employee divorces or legally separates from spouse.	36 months
6.	Employee becomes entitled to Medicare.	36 months
7.	Dependent child no longer qualifies as dependent child under the Plan.	36 months

* If the covered person becomes disabled during the first 60 days of this 18-month period, the coverage can be continued for an additional 11 months (i.e., for a total of 29 months). The covered person must meet the Social Security definition of "disabled" in order for this provision to apply.

You must notify the Employee Benefits Department if you become divorced or legally separated, or if your child no longer qualifies as a dependent under the terms of this Plan, within sixty (60) days in order to continue coverage.

The COBRA Administrator will contact you or your dependent(s) by providing a COBRA "Qualifying Event Letter," to enable election of continued dental coverage.

You or your dependent(s) will have sixty (60) days from the date coverage would otherwise terminate or from the date the COBRA Administrator notifies you or your dependent(s) of the rights to continue the coverage, whichever is later, to decide if you want to continue coverage.

Any person who elects to continue the group dental coverage must pay the full cost of the coverage, plus an additional 2% of that cost. This includes the share that you may now pay. The COBRA Administrator will inform you and your dependent(s) of the cost of the coverage when the notification is sent to you.

If you or your dependent(s) choose to continue coverage after the event occurs, there will be a forty-five (45) day period for the initial payment of the premium from the date you or your dependent(s) choose to continue coverage.

If the benefits or cost of the benefits change, you will be notified of any such change.

CLAIMS REVIEW PROCEDURE

Any person who believes he or she is being denied any rights or benefits under the Plan, is required to file a claim in writing with the Plan Manager.

Notice of Denied Claim

If your claim is denied in whole or in part, you will be notified in writing by the Plan Manager within 30 days of the date the Plan Manager received your claim. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Manager, including in cases where a claim is incomplete. The Plan Manager will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Manager is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will suspend the time for a decision on your claim until the specified information is provided.

Notification of a denied claim will set out:

- the specific reason or reasons for the denial;
- the specific plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary; and
- appropriate information on the steps to be taken if you wish to appeal the Plan Manager's decision, including your right to submit written comments and have them considered, and your right to review (upon request and at no charge) relevant documents and other information.

Appeal of Denied Claim

If your claim is denied in whole or in part, you (or your authorized representative) may request review upon written application to the Plan Manager. Your appeal must be made in writing within 60 days of your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Your appeal will be reviewed and decided by the Plan Manager or other entity designated in the plan in a reasonable time not later than 30 days after the Plan Manager receives your request for review. The Plan Manager may, in its discretion, hold a hearing on the denied claim. Any medical or dental expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical or dental expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific plan provision(s) on which the decision is based;

- a statement of your right to review (upon request and at no charge) relevant documents and other information; and

- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If you are not satisfied with the Plan Manager's appeal determination, you may appeal to the Plan Administrator. Your appeal must be made in writing within 60 days of the initial appeal determination.

ADMINISTRATION

The Plan will be managed for claims payments and customer service by Excellus.

All dental plan records for you and your family will be kept at the office of Excellus. A copy of the Enrollment Form will be kept in the RCSD Employee Benefits Department. All records will be kept confidential, except as may be necessary to determine the appropriate level of benefits which are payable.

Plan Manager: Excellus BlueCross Blue Shield ("Excellus")
165 Court Street
Rochester, NY 14647
(800) 499-1275

Plan Administration of a legal or regulatory nature is the responsibility of the Rochester City School District, which is officially designated as the Plan Administrator. The dental plan is self-insured by RCSD.

Plan Administrator: Rochester City School District
131 Broad Street
Rochester, NY 14614
(585) 262-8206

Plan Year: The Plan Year is January 1st through December 31st.

Benefit Year: The Benefit Year is January 1st through December 31st.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the legal obligations of the group health plan sponsored by Rochester City School District (the "Plan" for purposes of this Notice) and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices (the "Notice") to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, or on behalf of a group health plan that relates to:

1) your past, present or future physical or mental health or condition;
2) the provision of health care to you; or
3) the past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the Privacy Officer at (585) 262-8206.

Effective Date

This Notice is effective January 1, 2017.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to
  your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices via e-mail, or by mailing to your last-known address on file.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and

disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, effective September 23, 2013, the Plan is prohibited from using or disclosing genetic information for underwriting purposes.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose protected health information to certain company employees. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA,

unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contacting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official--

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;

- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:

1) the individual identifiers have been removed; or
2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or

2) treating such person as your personal representative could endanger you; and
3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the participant. This includes mail relating to the participant's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the participant's spouse and other family members and information on the denial of any Plan benefits to the participant's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. Effective September 23, 2013, specific disclosures that require your authorization include most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information. You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. Effective September 23, 2013, if certain protected health information is maintained in a designated record set, you have the right to obtain electronic copies of your protected health information. To inspect and copy your protected health information, you must submit your request in writing to the Privacy Officer at the Rochester City School District, 131 West Broad Street, Rochester, NY 14614. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, electronically reproducing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Privacy Officer at the Rochester City School District, 131 West Broad Street, Rochester, NY 14614.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the Rochester City School District, 131 West Broad Street, Rochester, NY 14614. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the Rochester City School District, 131 West Broad Street, Rochester, NY 14614. Your request must state a time period of not longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

Effective February 17, 2010 (or such other date specified as the effective date under applicable law), we will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing to the Privacy Officer at the Rochester City School District, 131 West Broad Street, Rochester, NY 14614. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply--for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer at the Rochester City School District, 131 West Broad Street, Rochester, NY 14614. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice contact, the Privacy Officer at the Rochester City School District, 131 West Broad Street, Rochester, NY 14614.

Right to opt-out of Receiving Fundraising Communications. Although the Plan has the right to contact you regarding fundraising activities, effective September 23, 2013, you have the right to opt out of receiving such communications.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Privacy Officer at the Rochester City School District, 131 West Broad Street, Rochester, NY 14614. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us.

APPENDIX A

Participating
Schedule of Allowances

Excellus Fee Schedule

Excellus BlueCross BlueShield

2017 Dental Schedule of Allowances

Effective January 1, 2017

Procedure Code	Procedure Description	Current Allowance
D0120	PERIODIC ORAL EXAMINATION	30.00
D0140	LIMITED ORAL EVALUATION,PROBLEM FOCUSED	39.00
D0145	ORAL EVAL <3 YRS & COUNS W/PRIM CARGIVER	NC
D0150	COMPREHENSIVE ORAL EVALUATION	47.00
D0160	DETAILED EXTENSIVE ORAL EVALUATION	NC
D0170	RE-EVALUATION LIMITED PROBLEM FOCUSED	NC
D0171	RE-EVALUATION POST-OPERATIVE VISIT	NC
D0180	COMPREHENSIVE PERIODONTAL EVALUATION	NC
D0190	SCREENING OF PATIENT	NC
D0191	ASSESSMENT OF PATIENT	NC
D0210	INTRAORAL COMPL SERIES, RADIOGRAPHIC IMAGES	108.40
D0220	INTRAORAL PERIAPICAL,FIRST RADIOGRAPHIC IMAGE	16.26
D0230	INTRAORAL EA ADD RADIOGRAPHIC IMAGE	13.55
D0240	INTRAORAL OCCLUSAL RADIOGRAPHIC IMAGE	20.33
D0250	EXTRAORAL FIRST RADIOGRAPHIC IMAGE	29.00
D0251	EACH EXTRA-ORAL POSTERIOR REDIOGRAPHIC IMAGE	27.10
D0260	EXTRAORAL EA ADD RADIOGRAPHIC IMAGE	21.00
D0270	BITEWING, SINGLE RADIOGRAPHIC IMAGE	16.26
D0272	BITEWINGS, TWO RADIOGRAPHIC IMAGES	29.81
D0273	BITEWINGS, THREE RADIOGRAPHIC IMAGES	35.00
D0274	BITEWINGS, FOUR RADIOGRAPHIC IMAGES	44.00
D0277	BITEWINGS 7 TO 8 VERTICAL RADIOGRAPHIC IMAGES	55.56
D0290	SKULL AND FACIAL BONE SURVEY RADIOGRAPHIC IMAGE	NC
D0310	SIALOGRAPHY	162.60
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM	NC
D0321	TEMPOROMANDIBULAR JOINT IMAGES, OTHER	NC
D0322	TOMOGRAPHIC SURVEY	NC
D0330	PANORAMIC RADIOGRAPHIC IMAGE	74.53
D0340	CEPHALOMETRIC RADIOGRAPHIC IMAGE	73.44
D0350	ORAL/FACIAL PHOTOGRAPHIC IMAGES	13.00
D0351	3D PHOTO IMAGE	NC
D0364	CONE BEAM- LESS THAN ONE WHOLE JAW	NC
D0365	CONE BEAM- FULL ARCH MANDIBLE	NC
D0366	CONE BEAM- FULL ARCH MAXILLA	NC
D0367	CONE BEAM- BOTH JAWS	NC
D0368	CONE BEAM - TMJ	NC
D0369	MRI CAPTURE AND INTERPRET	NC
D0370	MAXILLOFACIAL ULTRASOUND	NC
D0371	SIALENDOSCOPY - CAPTURE AND INTERPRET	NC
D0380	CONE BEAM- LESS THAN WHOLE JAW, IMAGE ONLY	NC
D0381	CONE BEAM- FULL ARCH MANDIBLE, IMAGE ONLY	NC
D0382	CONE BEAM- FULL ARCH MAXILLA, IMAGE ONLY	NC
D0383	CONE BEAM- BOTH JAWS, IMAGE ONLY	NC
D0384	CONE BEAM - TMJ, IMAGE ONLY	NC
D0385	MRI- MAXILLOFACIAL, IMAGE ONLY	NC
D0386	MAXILLOFACIAL ULTRASOUND, IMAGE ONLY	NC
D0391	INTERPRETATION OF IMAGE	NC
D0393	TREATMENT SIMULATION USING 3D IMAGE VOLUME	NC
D0394	DIGITAL SUBTRACTION OF TWO OR MORE IMAGES	NC
D0395	FUSION OF TWO OR MORE 3D IMAGES	NC
D0415	COLLECTION OF MICROORGANISMS	NC
D0416	VIRAL CULTURE	NC
D0417	COLLECTION & PREP OF SALIVA SAMPLE	NC
D0418	ANALYSIS OF SALIVA SAMPLE	NC
D0422	COLLECT GENETIC MAT FOR LAB ANALYSIS	NC
D0423	GENETIC TEST DISEASES – SPECIMEN ANALYSIS	NC
D0425	CARIES SUSCEPTIBILITY TESTS	NC
D0431	ADJUNCTIVE PRE-DX TEST	NC
D0460	TEST:PULP VITALITY	24.50
D0470	DIAGNOSTIC CASTS	NC
D0472	LAB:ACCESSION OF TISSUE GROSS EXAM	NC
D0473	LAB:ACCESSION OF TISSUE GROSS/MICRO EXAM	NC
D0474	LAB:ACCESSION OF TISSUE INCL ASSESSMENT	NC
D0475	DECALCIFICATION PROCEDURE	NC
D0476	SPECIAL STAINS FOR MICROORGANISMS	NC
D0477	SPECIAL STAINS, NOT FOR MICROORGANISMS	NC
D0478	IMMUNOHISTOCHEMICAL STAINS	NC
D0479	TISSUE IN-SITU HYBRIDIZATION, INCL INTERP	NC
D0480	LAB:PROC & INTERPRET CYTOLOGIC SMEARS	NC
D0481	ELECTON MICROSCOPY - DIAGNOSTIC	NC
D0482	DIRECT IMMUNOFLUORESCENCE	NC
D0483	INDIRECT IMMUNOFLUORESCENCE	NC
D0484	CONSULTATION ON SLIDES PREP ELSEWHERE	NC
D0485	CONSULTATION, INCL PREPARATION OF SLIDES	NC
D0486	LAB ANALYSIS OF TRANSEPITHELIAL SAMPLE	NC
D0502	OTHER ORAL PATHOLOGY PROCEDURES	NC
D0601	CARIES RISK ASSESSMENT & DOCUMENT, LOW RISK	NC
D0602	CARIES RISK ASSESSMENT & DOCUMENT, MOD RISK	NC
D0603	CARIES RISK ASSESSMENT & DOCUMENT, HIGH RISK	NC
D0999	UNSPECIFIED DIAGNOSTIC PROCEDURE	SC
D1110	ADULT PROPHYLAXIS	67.00
D1120	CHILD PROPHYLAXIS	49.00
D1206	TOPICAL APPLICATION FLUORIDE VARNISH	20.33
D1208	TOPICAL FLUORIDE	20.33
D1310	NUTRITIONAL COUNSELING / DENTAL DISEASE	NC
D1320	TOBACCO COUNSELING PREVENTION OF DISEASE	NC
D1330	INSTRUCTION:ORAL HYGIENE	NC
D1351	TOP APPL SEALANTS:PER TOOTH	29.81
D1352	PREVENTIVE RESIN RESTORATION, HIGH CARIES RISK PT	NC
D1353	SEALANT REPAIR - PER TOOTH	NC
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION	NC
D1510	SPACE MAINTAINER UNILATERAL FIXED	158.03
D1515	SPACE MAINTAINERS BILATERAL FIXED	268.28
D1520	SPACE MAINTAINER UNILATERAL REMOVABLE	158.03
D1525	SPACE MAINTAINER BILATERAL REMOVABLE	268.28
D1550	RECEMENT:SPACE MAINTAINER	57.58
D1555	REMOVAL OF FIXED SPACE MAINTAINER	NC
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY REPORT	SC
D2140	AMALGAM: 1 SURFACE, PRIMARY OR PERMANENT	77.18
D2150	AMALGAM: 2 SURFACE, PRIMARY OR PERMANENT	94.33
D2160	AMALGAM: 3 SURFACE, PRIMARY OR PERMANENT	118.83
D2161	AMALGAM: 4 OR MORE, PRIMARY OR PERMANENT	118.83
D2330	RESIN:ONE SURFACE ANTERIOR	95.00
D2331	RESIN:TWO SURFACES ANTERIOR	119.00
D2332	RESIN:THREE SURFACES ANTERIOR	139.00
D2335	RESIN,4 OR MORE SURFACES/INCISAL ANGLE	165.38
D2390	RESIN COMPOSITE CROWN	159.25
D2391	RESIN COMPOSITE 1 SURFACE POSTERIOR	122.50
D2392	RESIN COMPOSITE 2 SURFACE POSTERIOR	147.00
D2393	RESIN COMPOSITE 3 SURFACE POSTERIOR	171.50

Procedure Code	Procedure Description	Current Allowance
D2394	RESIN COMPOSITE 4 OR MORE SURF POST	171.50
D2410	GOLD FOIL:ONE SURFACE	NC
D2420	GOLD FOIL:TWO SURFACES	NC
D2430	GOLD FOIL:THREE SURFACES	NC
D2510	METALLIC INLAY:ONE SURFACE	147.00
D2520	METALLIC INLAY:TWO SURFACES	502.25
D2530	METALLIC INLAY: THREE OR MORE	563.50
D2542	METALLIC ONLAY:TWO SURFACES	502.25
D2543	METALLIC ONLAY:3 SURFACES	655.38
D2544	METALLIC ONLAY: 4 OR MORE SURFACES	655.38
D2610	INLAY:ONE SURFACE PORCE/CERAMIC	147.00
D2620	INLAY:TWO SURFACE PORCE/CERAMIC	502.25
D2630	INLAY: THREE OR MORE PORC/CERAMIC	563.50
D2642	ONLAY:PORCELAIN/CERAMIC-2 SURFACES	502.25
D2643	ONLAY:PORCELAIN/CERAMIC-3 SURFACES	655.38
D2644	ONLAY:PORCELAIN/CERAMIC-4 OR MORE SURF	655.38
D2650	INLAY:COMPOSITE/RESIN-ONE SURFACE	147.00
D2651	INLAY:COMPOSITE/RESIN-TWO SURFACES	502.25
D2652	INLAY: COMPOSITE/RESIN 3 OR MORE	563.50
D2662	ONLAY:COMPOSITE/RESIN-2 SURFACES	502.25
D2663	ONLAY:COMPOSITE/RESIN-3 SURFACES	655.38
D2664	ONLAY:COMPOSITE/RESIN-4 OR MORE SURF	655.38
D2710	RESIN-BASED COMPOSITE, INDIRECT	366.28
D2712	CROWN-3/4 RESIN	735.00
D2720	CROWN:RESIN WITH HIGH NOBLE METAL	833.00
D2721	CROWN:RESIN WITH BASE METAL	698.25
D2722	CROWN:RESIN WITH NOBLE METAL	764.40
D2740	CROWN:PORCELAIN/CERAMIC SUBSTRATE	951.00
D2750	CROWN:PORCELAIN FUSED HIGH NOBLE METAL	870.00
D2751	CROWN:PORCELAIN FUSED TO BASE METAL	772.98
D2752	CROWN:PORCELAIN FUSED TO NOBLE METAL	842.80
D2780	CROWN:3/4 CAST HIGH NOBLE METAL	735.00
D2781	CROWN:3/4 CAST PREDOMINATELY BASE METAL	735.00
D2782	CROWN:3/4 CAST NOBLE METAL	735.00
D2783	CROWN:3/4 PORCELAIN/CERAMIC	735.00
D2790	CROWN:FULL CAST HIGH NOBLE METAL	868.00
D2791	CROWN:FULL CAST BASE METAL	772.98
D2792	CROWN:FULL CAST NOBLE METAL	820.75
D2794	CROWN - TITANIUM	820.75
D2799	PROVISIONAL CROWN	NC
D2910	RECEMENT INLAY, ONLAY OR PARTIAL COV. REST	61.25
D2915	RECEMENT CAST OR PREFAB POST AND CORE	SC
D2920	RECEMENT CROWN	62.00
D2921	REATTACHMENT TOOTH FRAGMENT, INCISAL EDGE/CUSP	NC
D2929	PREFAB PORCELAIN/CERAMIC CROWN PRIMARY TOOTH	177.48
D2930	CROWN:STAINLESS STEEL PRIMARY TOOTH	159.25
D2931	CROWN:STAINLESS STEEL PERMANENT TOOTH	177.63
D2932	CROWN:RESIN PREFABRICATED	230.30
D2933	PREFAB STAINLESS STEEL/RESIN CROWN	177.63
D2934	PREFAB ESTHETIC COATED STAINLESS STL CR	159.25
D2940	PROTECTIVE RESTORATION	63.70
D2941	INTERIM THERAPEUTIC RESTORATION-PRIMARY DENT	63.70
D2949	RESTORATIVE FOUNDATION / INDIRECT RESTORATION	NC
D2950	CORE BUILD-UP, INCL PINS	SC
D2951	PIN RETENTION:PER TOOTH IN ADDTN TO REST	18.38
D2952	CAST POST & CORE IN ADDTN TO CROWN	220.50
D2953	CAST POST:EACH ADDITIONAL-SAME TOOTH	NC
D2954	PREFAB.POST & CORE IN ADDITION TO CROWN	160.48
D2955	POST REMOVAL	NC
D2957	PREFAB POST:EACH ADDITIONAL	NC
D2960	LABIAL VENEER (LAMINATE) CHAIRSIDE	245.00
D2961	LABIAL VENEER (RESIN LAMINATE)LABORATORY	355.25
D2962	LABIAL VENEER (PORCELAIN LAMINATE) LAB	524.30
D2971	ADDITIONAL PROCS TO CONSTR NEW CROWN	NC
D2975	COPING	367.50
D2980	CROWN REPAIR, NECESS BY RESTOR MATERIAL FAIL	SC
D2981	INLAY REPAIR	SC
D2982	ONLAY REPAIR	SC
D2983	VENEER REPAIR	SC
D2990	RESIN INFILTRATION	45.90
D2999	RESTORATION UNSPECIFIED PROC	SC
D3110	PULP CAP:DIRECT,EXCL.FINAL RESTORATION	SC
D3120	PULP CAP:INDIRECT,EXCL.FINAL RESTORATION	SC
D3220	PULPOTOMY THERAPEUTIC	78.00
D3221	PULPAL DEBRIDEMENT, PRIMARY AND PERM	73.50
D3222	PARTIAL PULPOTOMY FOR APEXOGENISIS	73.50
D3230	PULPAL THERAPY,ANTERIOR,PRIMARY TOOTH	147.00
D3240	PULPAL THERAPY,POSTERIOR,PRIMARY TOOTH	220.50
D3310	ROOT CANAL:ANTERIOR	496.13
D3320	ROOT CANAL:BICUSPID	772.75
D3330	ROOT CANAL:MOLAR	888.13
D3331	TREATMENT OF ROOT CANAL OBSTRUCTION	NC
D3332	INCOMPLETE ENDODONTIC THERAPY	SC
D3333	ROOT REPAIR:INTERNAL	NC
D3346	RETREATMENT-ANTERIOR,BY REPORT	554.93
D3347	RETREATMENT-BICUSPID,BY REPORT	808.50
D3348	RETREATMENT-MOLAR,BY REPORT	994.70
D3351	APEXIFICATION/RECALCIFICATION-INITIAL	122.50
D3352	APEXIFICATION/RECALCIFICATION-INTERIM	98.00
D3353	APEXIFICATION/RECALCIFICATION-FINAL	496.13
D3355	PULPAL REGENERATION-INITIAL	122.50
D3356	PULPAL REGENERATION-INTERIM MED REPLACEMENT	98.00
D3357	PULPAL REGENERATION-COMPLETION OF TREATMENT	496.13
D3410	APICOECTOMY/PERIRADICULAR SURGERY, ANTERIOR	546.35
D3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUS	671.30
D3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR	755.83
D3426	APICOECTOMY,(PER TOOTH) EACH ADDTNL ROOT	126.18
D3427	PERIADICULARE SURGERY WITHOUT APECOECTOMY	NC
D3428	BONE GRAFT W/ PERIRADICULAR SURGERY PER TOOTH	NC
D3429	BONE GRAFT W/ PERIRADICULAR SURGERY ADD TOOTH	NC
D3430	RETROGRADE FILLING PER ROOT	122.50
D3431	BIOLOGIC MATERIALS TO AID IN SOFT & OSSEOUS TISSUE	NC
D3432	GUIDED TISSUE REGEN, RESORB BARRIER, PER SITE	NC
D3450	ROOT AMPUTATION PER ROOT	306.25
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	NC
D3470	INTENTIONAL REPLANTATION (INC SPLINTING)	NC
D3910	SURGICAL ISOLATION PROCEDURE	NC
D3920	HEMISECTION (INCL ROOT REMOVAL)	306.25
D3950	CANAL PREP FOR DOWEL/POST	NC
D3999	ENDODONTIC UNSPECIFIED SERVICE	SC
D4210	GINGIVECTOMY OR GINGIVOPLASTY, QUAD	393.00
D4211	GINGIVECTOMY OR GINGIVOPLASTY, 1-3 TH QD	85.75
D4212	GINGIVECTOMY OR GINGIVOPLASTY, FOR RESTOR	NC
D4230	ANATOMICAL CROWN EXPOSURE, 4 OR MORE TH	NC
D4231	ANATOMICAL CROWN EXPOSURE, 1-3 TEETH	NC
D4240	GINGIVAL FLAP PROC (**CASE TYPE II, III**)	535.33
D4240	GINGIVAL FLAP PROC (**CASE TYPE IV, V**)	690.90
D4241	GING FLAP PROC, 1-3 TH QD (**CASE TYPE II, III**)	200.90
D4241	GING FLAP PROC, 1-3 TH QD (**CASE TYPE IV, V**)	258.48
D4245	GINGIVAL APICALLY POSITIONED FLAP PROC	NC
D4249	CROWN LENGTHENING-HARD/SOFT TISSUE	SC
D4260	OSSEOUS SURG, QUAD (**CASE TYPE II, III**)	776.65

Procedure Code	Procedure Description	Current Allowance
D4260	OSSEOUS SURG, QUAD (**CASE TYPE IV, V**)	949.38
D4261	OSSEOUS SURG, 1-3 TH QD (**CASE TYPE II, III**)	388.33
D4261	OSSEOUS SURG, 1-3 TH QD (**CASE TYPE IV, V**)	475.30
D4263	BONE REPLACEMENT GRAFT, 1ST SITE QUAD	NC
D4264	BONE REPLACEMENT GRAFT, EACH ADDIT SITE	NC
D4265	BIOLOGIC MATERIALS FOR SFT TISS REGEN	NC
D4266	GUIDED TISSUE REGENERATION,RESORBABLE	NC
D4267	GUIDED TISSUE REGENERATION, NONRESORB	NC
D4268	FLAP SURGICAL REVISION PER TOOTH	NC
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	NC
D4273	SUBEPITHELIAL CONNECTIVE TIS GRAFT, PER TH	NC
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	NC
D4275	SOFT TISSUE ALLOGRAFT	NC
D4276	COMB CONN TISS & DBL PEDICLE GRAFT, PER TH	NC
D4277	FREE SOFT TISSUE GRAFT FIRST TOOTH	NC
D4278	FREE SOFT TISSUE GRAFT ADDITIONAL TEETH	NC
D4283	AUTO CON GRAFT –EA ADD TOOTH	NC
D4285	NON-AUTO GRAFT – EA ADD TOOTH	NC
D4320	PROVIS SPLINTING INTRACORONAL	NC
D4321	PROVIS SPLINTING EXTRACORONAL	NC
D4341	PERIO SCAL & RT PLANING, QD (**CASE TYPE II, III**)	116.38
D4341	PERIO SCAL & RT PLANING, QD (**CASE TYPE IV, V**)	172.73
D4342	PERIO SCALING, 1-3 TH QD (**CASE TYPE II, III**)	44.10
D4342	PERIO SCALING, 1-3 TH QD (**CASE TYPE IV, V**)	64.93
D4355	FULL MOUTH DEBRIDEMENT FOR EVAL AND DX	NC
D4381	LOCALIZED DELIV OF ANTIMICROBIAL AGENTS	NC
D4910	PERIODONTAL MAINTENANCE	85.00
D4920	DRESSING CHANGES UNSCHEDULED	NC
D4921	GINGIVAL IRRIGATION - PER QUADRANT	NC
D4999	PERIODONTAL UNSPECIFIED PROC BY REPORT	SC
D5110	DENTURE:FULL UPPER	1102.50
D5120	DENTURE:FULL LOWER	1102.50
D5130	DENTURE:UPPER IMMEDIATE	1276.45
D5140	DENTURE:LOWER IMMEDIATE	1276.45
D5211	PARTIAL UPPER ACRYLIC BASE	714.18
D5212	PARTIAL LOWER ACRYLIC BASE	714.18
D5213	UPPER PARTIAL: CAST BASE/RESIN SADDLES	1119.65
D5214	LOWER PARTIAL: CAST BASE/RESIN SADDLES	1119.65
D5221	IMMEDIATE MAX PARTIAL DENTURE/ RESIN BASE	714.18
D5222	IMMEDIATE MAND PARTIAL DENTURE/ RESIN BASE	714.18
D5223	MAXILLARY CAST METAL RESIN DENTURE	1119.65
D5224	MANDIBULAR CAST METAL RESIN DENTURE	1119.65
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE	1119.65
D5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE	1119.65
D5281	PARTIAL REMOV UNILATERAL BASE CASTING	485.10
D5410	ADJUST COMPLETE UPPER DENTURE	49.00
D5411	ADJUST COMPLETE LOWER DENTURE	49.00
D5421	ADJUST PARTIAL UPPER DENTURE	49.00
D5422	ADJUST PARTIAL LOWER DENTURE	49.00
D5510	REPAIR:BROKEN BASE COMPLETE DENTURE	105.35
D5520	REPLACE BROKEN TOOTH COMPL DENT	122.50
D5610	DENT:REPAIR ACRYLIC SADDLE OR BASE	122.50
D5620	DENT:REPAIR CAST FRAMEWORK	SC
D5630	DENT:REPAIR OR REPLACE BROKEN CLASP	154.35
D5640	DENT:REPLACE BROKEN TEETH,PER TOOTH	85.75
D5650	ADD TOOTH TO PARTIAL DENTURE (EXISTING)	134.75
D5660	ADD CLASP TO PARTIAL DENTURE (EXISTING)	159.25
D5670	REPLACE ALL TH & ACRYLIC MAX	NC
D5671	REPLACE ALL TH & ACRYLIC MAND	NC
D5710	REBASE COMPLETE UPPER DENTURE	367.50
D5711	REBASE COMPLETE LOWER DENTURE	367.50
D5720	REBASE(JUMP) PARTIAL UPPER DENTURE	367.50
D5721	REBASE(JUMP) PARTIAL LOWER DENTURE	367.50
D5730	RELINE UPPER COMPLETE DENTURE CHAIRSIDE	245.00
D5731	RELINE LOWER COMPLETE DENTURE CHAIRSIDE	245.00
D5740	RELINE UPPER PARTIAL DENTURE CHAIRSIDE	245.00
D5741	RELINE LOWER PARTIAL DENTURE CHAIRSIDE	245.00
D5750	RELINE COMPLETE UPPER DENT LABORATORY	367.50
D5751	RELINE COMPLETE LOWER DENT LABORATORY	367.50
D5760	RELINE UPPER PARTIAL DENT LABORATORY	306.25
D5761	RELINE LOWER PARTIAL DENT LABORATORY	306.25
D5810	TEMPORARY UPPER COMPLETE DENTURE	NC
D5811	TEMPORARY LOWER COMPLETE DENTURE	NC
D5820	STAYPLATE UPPER PARTIAL, ANTERIOR ONLY	306.25
D5821	STAYPLATE LOWER PARTIAL, ANTERIOR ONLY	306.25
D5850	TISSUE CONDITIONING UPPER/DENTURE UNIT	85.75
D5851	TISSUE CONDITIONING LOWER/DENTURE UNIT	85.75
D5862	PRECISION ATTACHMENT	NC
D5863	OVERDENTURE-COMPLETE MAXILLARY	1064.53
D5864	OVERDENTURE-PARTIAL MAXILLARY	1064.53
D5865	OVERDENTURE-COMPLETE MANDIBULAR	1064.53
D5866	OVERDENTURE-PARTIAL MANDIBULAR	1064.53
D5867	REPLACEABLE PART SEMI/PRECISION ATTACH	NC
D5875	MODIFY REMOVABLE PROSTHESIS POST IMPLANT	NC
D5899	UNSPECIFIED REMOVABLE PROSTHETIC	SC
D5911	FACIAL MOULAGE SECTIONAL	NC
D5912	FACIAL MOULAGE COMPLETE	NC
D5913	NASAL PROSTHESIS	NC
D5914	AURICULAR PROSTHESIS	NC
D5915	ORBITAL PROSTHESIS	NC
D5916	OCULAR PROSTHESIS	NC
D5919	PROSTHETIC DRESSING	NC
D5922	NASAL SEPTAL PROSTHESIS	NC
D5923	OCULAR PROSTHESIS,INTERIM	NC
D5924	CRANIAL PROSTHESIS	NC
D5925	FACIAL AUGMENTATION IMPLANT PROSTHESIS	NC
D5926	NASAL PROSTHESIS,REPLACEMENT	NC
D5927	AURICULAR PROSTHESIS,REPLACEMENT	NC
D5928	ORBITAL PROSTHESIS,REPLACEMENT	NC
D5929	FACIAL PROSTHESIS,REPLACEMENT	NC
D5931	OBTURATOR PROSTHESIS,SURGICAL	1102.50
D5932	OBTURATOR:POSTSURGICAL	1102.50
D5933	REFITTING OF OBTURATOR	NC
D5934	MANDIBULAR RESECTION FLANGE PROSTHESIS	NC
D5935	MANDIBULAR RESECTION DENTURE PROSTHESIS	NC
D5936	OBTURATOR PROSTHESIS,INTERIM	NC
D5937	TRISMUS APPLIANCE- NOT FOR TMD TREATMENT	NC
D5951	FEEDING AID	NC
D5952	PEDIATRIC SPEECH AID	NC
D5953	ADULT SPEECH AID	NC
D5954	SUPERIMPOSED PROSTHESIS	NC
D5955	PALATAL LIFT PROSTHESIS	NC
D5958	PALATAL LIFT PROSTHESIS,INTERIM	NC
D5959	PALATAL LIFT PROSTHESIS,MODIFICATION	NC
D5960	SPEECH AID PROSTHESIS,MODIFICATION	NC
D5982	SURGICAL STENT	NC
D5983	RADIATION CARRIER	NC
D5984	RADIATION SHIELD	NC
D5985	DOCKING DEVICE CONE LOCATOR	NC
D5986	FLUORIDE APPLICATOR PER ARCH	NC
D5987	COMMISSURE SPLINT	NC
D5988	SURGICAL SPLINT	NC

Procedure Code	Procedure Description	Current Allowance
D5991	TOPICAL MEDICAMENT CARRIER	NC
D5992	ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE	NC
D5993	MAINTENANCE/CLEANING MAXILLOFACIAL PROSTHETIC	NC
D5994	PERIODONTAL MEDICAMENT CARRIER	NC
D5999	UNSPECIFIED MAXILLOFACIAL PROSTHESIS	SC
D6010	ENDOSTEAL IMPLANT	1715.00
D6011	SECOND STAGE IMPLANT SURGERY	NC
D6012	SURGICAL PLACEMENT OF INTERIM IMPLANT	NC
D6013	SURGICAL PLACEMENT OF A MINI IMPLANT	NC
D6040	SUBPERIOSTEAL IMPLANT	NC
D6050	TRANSOSSEOUS IMPLANT	NC
D6051	INTERIM ABUTMENT	NC
D6052	SEMI-PRECISION ATTACHMENT ABUTMENT	NC
D6055	IMPLANT CONNECTING BAR	NC
D6056	PREFAB ABUTMENT - INCLUDES MOD & PLACEMENT	562.28
D6057	CUSTOM ABUTMENT - INCLUDES MOD & PLACEMENT	715.40
D6058	IMPLANT:ABUTMENT SUPPORT PORC/CER CROWN	950.60
D6059	IMPLANT:ABUT SUPP PORC FUSED METAL CROWN	859.95
D6060	IMPLANT:ABUT SUPP PORC BASE METAL CROWN	772.96
D6061	IMPLANT:ABUT SUPP PORC NOBLE METAL CROWN	842.80
D6062	IMPLANT:ABUT SUP HIGH NOBLE METAL CROWN	861.18
D6063	IMPLANT:ABUT SUPP CAST METAL BASE METAL	772.98
D6064	IMPLANT:ABUT SUPP CAST METAL NOBLE CROWN	820.75
D6065	IMPLANT:SUPPORTED PORC/CERAMIC CROWN	950.63
D6066	IMPLANT:SUPP PORC FUSED TO METAL CROWN	859.95
D6067	IMPLANT:SUPP METAL CROWN	861.68
D6068	IMPLANT:ABUT SUPP RETAINER PORC/CER FPD	NC
D6069	IMPLANT:ABUT SUPP RET PORC HIGH MET FPD	NC
D6070	IMPLANT:ABUT SUP RET PORC BASE MET FPD	NC
D6071	IMPLANT:ABUT SUPP RET PORC NOBLE MET FPD	NC
D6072	IMPLANT:ABUT SUPP RET CAST FPD HIGH NOBL	NC
D6073	IMPLANT:ABUT SUPP RET CAST FPD BASE MET	NC
D6074	IMPLANT:ABUT SUPP RET CAST FPD NOBLE MET	NC
D6075	IMPLANT: SUPP RETAINER FOR CERAMIC FPD	NC
D6076	IMPLANT:SUPP RET PORC FUSED METAL FPD	NC
D6077	IMPLANT:SUPP RET CAST METAL FPD	NC
D6080	IMPLANT MAINTENANCE PROCEDURES	NC
D6090	REPAIR IMPLANT,BY REPORT	SC
D6091	REPLACEMENT OF SEMI-PRECISION/PREC ATTACHM	NC
D6092	RECEMENT IMPLANT/ABUTMENT SUPPORTED CRN	61.25
D6093	RECEMENT IMPLANT/ABUTMENT SUPP FIXED PAR	NC
D6094	ABUTMENT SUPPORTED CROWN (TITANIUM)	820.75
D6095	REPAIR IMPLANT ABUTMENT,BY REPORT	SC
D6100	IMPLANT REMOVAL,BY REPORT	SC
D6101	DEBRIDEMENT- PERIIMPLANT DEFECT	NC
D6102	DEBRIDEMENT & OSSEUS CONTOURING- PERIIMPLANT	NC
D6103	BONE GRAFT FOR PERIIMPLANT REPAIR	NC
D6104	BONE GRAFT AT TIME OF IMPLANT PLACEMENT	NC
D6110	IMPLANT-ABUT SUPP REMOVABLE DENTURE -EDENTULOUS ARCH -MAXILLARY	NC
D6111	IMPLANT-ABUT SUPP REMOVABLE DENTURE -PARTIALLY EDENTULOUS ARCH -MAXILLARY	NC
D6112	IMPLANT-ABUT SUPP REMOVABLE DENTURE -PARTIALLY EDENTULOUS ARCH -MAXILLARY	NC
D6113	IMPLANT-ABUT SUPP REMOVABLE DENTURE -PARTIALLY EDENTULOUS ARCH -MANDIBULAR	NC
D6114	IMPLANT-ABUT SUPP FIXED DENTURE -EDENTULOUS ARCH -MAXILLARY	NC
D6115	IMPLANT-ABUT SUPP FIXED DENTURE -EDENTULOUS ARCH -MANDIBULAR	NC
D6116	IMPLANT-ABUT SUPP FIXED DENTURE -PARTIALLY EDENTULOUS ARCH -MAXILLARY	NC
D6117	IMPLANT-ABUT SUPP FIXED DENTURE -PARTIALLY EDENTULOUS ARCH -MANDIBULAR	NC
D6190	RADIOGRAPHIC/SURG IMPLANT INDEX, BY REP	NC
D6194	ABUTMENT SUPP RTNR CROWN FOR FPD - TITAN	NC
D6199	UNSPECIFIED IMPLANT PROCEDURE	SC
D6205	PONTIC - INDIRECT RESIN BASED COMPOSITE	366.28
D6210	PONTIC:CAST HIGH NOBLE METAL	861.18
D6211	PONTIC:CAST PREDOMINANTLY BASE METAL	772.98
D6212	PONTIC:CAST NOBLE METAL	820.75
D6214	PONTIC - TITANIUM	820.75
D6240	PONTIC:PORCELAIN FUSED HIGH NOBLE METAL	859.95
D6241	PONTIC:PORCELAIN FUSED PREDOM BASE METAL	772.98
D6242	PONTIC:PORCELAIN FUSED TO NOBLE METAL	842.80
D6245	PONTIC:PORCELAIN/CERAMIC	950.60
D6250	PONTIC:RESIN WITH HIGH NOBLE METAL	833.00
D6251	PONTIC:RESIN WITH PREDOM BASE METAL	698.25
D6252	PONTIC:RESIN WITH NOBLE METAL	764.40
D6253	PROVISIONAL PONTIC	NC
D6545	CAST METAL RETAINER (MARYLAND BRIDGE)	221.73
D6548	RETAINER:PORCELAIN/CERAMIC	221.73
D6549	RESIN RETAINER - RESIN BONDED FIXED PROSTHESIS	221.73
D6600	INLAY-PORCELAIN/CERAMIC 2 SURFACES	502.25
D6601	INLAY-PORCELAIN/CERAMIC 3 OR MORE SURF	563.50
D6602	INLAY-CAST HIGH NOBLE METAL 2 SURFACES	502.25
D6603	INLAY-CAST HIGH NOBLE METAL 3 OR MORE	563.50
D6604	INLAY-CAST PRED BASE METAL 2 SURFACES	502.25
D6605	INLAY-CAST PRED BASE 3 OR MORE SURFACES	563.50
D6606	INLAY-CAST NOBLE METAL 2 SURFACES	502.25
D6607	INLAY-CAST NOBLE METAL 3 OR MORE	563.50
D6608	ONLAY-PORCELAIN/CERAMIC 2 SURFACES	502.25
D6609	ONLAY-PORCELAIN/CERAMIC 3 OR MORE	652.93
D6610	ONLAY-CAST HIGH NOBLE METAL 2 SURFACES	502.25
D6611	ONLAY-CAST HIGH NOBLE METAL 3 OR MORE	655.38
D6612	ONLAY-CAST PRED BASE METAL 2 SURFACES	502.25
D6613	ONLAY-CAST PRED BASE METAL 3 OR MORE	652.93
D6614	ONLAY-CAST NOBLE METAL 2 SURFACES	502.25
D6615	ONLAY-CAST NOBLE METAL 3 OR MORE	652.93
D6624	INLAY - TITANIUM	502.25
D6634	ONLAY - TITANIUM	502.25
D6710	CROWN - INDIRECT RESIN BASED COMPOSITE	366.28
D6720	CROWN:RESIN WITH HIGH NOBLE METAL	833.00
D6721	CROWN:RESIN WITH PREDOM BASE METAL	698.25
D6722	CROWN:RESIN WITH NOBLE METAL	764.40
D6740	CROWN:PORCELAIN/CERAMIC	950.60
D6750	CROWN:PORCELAIN FUSED HIGH NOBLE METAL	859.95
D6751	CROWN:PORCELAIN FUSED PREDOM BASE METAL	772.98
D6752	ABUT:PORCELAIN/NOBLE METAL	842.80
D6780	CROWN:3/4 CAST HIGH NOBLE METAL	735.00
D6781	CROWN:3/4 PREDOMINATELY BASE METAL	735.00
D6782	CROWN:3/4 CAST NOBLE METAL	735.00
D6783	CROWN:3/4 PORCELAIN/CERAMIC	735.00
D6790	CROWN:FULL CAST HIGH NOBLE METAL	861.18
D6791	CROWN:FULL CAST PREDOM BASE METAL	772.98
D6792	ABUT:NOBLE METAL FULL CAST	820.75
D6793	PROVISIONAL RETAINER CROWN	NC
D6794	CROWN - TITANIUM	820.75
D6920	CONNECTOR BAR	NC
D6930	RECEMENT BRIDGE	91.88
D6940	STRESS BREAKER	NC
D6950	PRECISION ATTACHMENT	NC
D6980	FIXED PARTIAL DENTURE, NEC BY REST MATER FAIL	SC
D6985	PEDIATRIC PARTIAL DENTURE, FIXED	NC
D6999	UNSPECIFIED PROSTHODONTIC PROCEDURE	SC
D7111	EXTRACTION, CORONAL REMNANTS - DECIDUOUS TEETH	53.90
D7140	EXTRACTION ERUPTED TH OR EXPOSED RT	107.80
D7210	EXTRACT:SURGICAL ERUPTED TOOTH	189.88
D7220	EXTRACT:SOFT TISSUE IMPACTION	237.65
D7230	EXTRACT:PARTIAL BONY IMPACTION	254.80

Procedure Code	Procedure Description	Current Allowance
D7240	EXTRACT:FULL BONY IMPACTION	338.10
D7241	EXTRACT:FULL BONY IMPACT, UNUSUAL	385.88
D7250	EXTRACT:RESIDUAL ROOT	122.50
D7251	CORONECTOMY: INTENTIONAL PART TOOTH REMOVAL	NC
D7260	CLOSURE:ORAL ANTRAL FISTULA	NC
D7261	PRIMARY CLOSURE OF SINUS PERFORATION	NC
D7270	TOOTH REIMPLANTATION	287.88
D7272	TRANSPLANTATION TOOTH	SC
D7280	SURGICAL ACCESS OF UNERUPTED TOOTH	306.25
D7282	MOBILIZATION OF ERUPTED TH TO AID ERPTN	171.50
D7283	PLACEMENT OF DEVICE TO FAC ERUPT OF IMP TH	*
D7285	BIOPSY OF HARD TISSUE	207.03
D7286	BIOPSY OF ORAL TISSUE - SOFT	123.73
D7287	EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	NC
D7288	BRUSH BIOPSY - TRANSEPITHELIAL SAMPLE COLL	NC
D7290	SURG REPOSITION TEETH	SC
D7291	TRASSEPTIAL FIBEROTOMY	NC
D7292	SURGICAL PLACEMENT (SCREW RETAINED PLT)	NC
D7293	SURG PLCMNT:TEMP ANCH DEVICE W/ SURG FLP	NC
D7294	SURG PLCMNT:TEMP ANCH DEVICE W/OUT SURG	NC
D7295	HARVEST OF BONE / GRAFTING	NC
D7310	ALVEOPLASTY W/EXTRACTIONS, PER QUAD	106.58
D7311	ALVEOPLASTY W/EXTRACTIONS, 1-3 TEETH	40.43
D7320	ALVEOPLASTY:NO EXTRACTIONS, PER QUAD	131.08
D7321	ALVEOPLASTY :NO EXTRACTIONS, 1-3 TEETH	49.00
D7340	RIDGE EXTENSION (SECONDARY EPITHELIAL)	SC
D7350	RIDGE EXTENSION INCL SOFT TISSUE GRAFTS	SC
D7410	EXCISE BENIGN LESION UP TO 1.25 CM.	SC
D7411	EXCISE BENIGN LESION > 1.25 CM	SC
D7412	EXCISION OF BENIGN LESION, COMPLICATED	NC
D7413	EXCISION OF MALIG LESION UP TO 1.25 CM	NC
D7414	EXCISION OF MALIG LESION OVER 1.25 CM	NC
D7415	EXCISION OF MALIG LESION, COMPLICATED	NC
D7440	MALIGNANT TUMOR TO 1.25 CM EXCISION	NC
D7441	MALIGNANT TUMOR > 1.25 CM EXCISION	NC
D7450	REMOVAL OF BENIGN CYST UP TO 1.25 CM	SC
D7451	REMOVAL BENIGN ODONTOGENIC CYST > 1.25 C	SC
D7460	CYST REMOVAL TO 1.25 CM NON-ODONTOGENIC	NC
D7461	CYST REMOVAL > 1.25 NON-ODONTOGENIC	NC
D7465	LESION(S):DESTRUCTION BY PHYSICAL METHOD	NC
D7471	REMOVAL OF LATERAL EXOSTOSIS	SC
D7472	REMOVE TORUS PALATINUS	SC
D7473	REMOVE TORUS MANDIBULARIS	SC
D7485	SURGICALLY REDUCE OSSEOUS TUBEROSITY	SC
D7490	RADICAL RESECTION OF MAXILLA OR MANDIBLE	NC
D7510	I&D ABSCESS INTRAORAL	138.43
D7511	I&D ABSCESS INTRAORAL - COMPLICATED	138.43
D7520	I&D ABSCESS EXTRAORAL	SC
D7521	I&D ABSCESS EXTRAORAL - COMPLICATED	SC
D7530	FOREIGN BODY REMOVAL	NC
D7540	REMOVE FOREIGN BODY REACTION PRODUCING	NC
D7550	PARTIAL OSTECTOMY/SEQUESTRECTOMY	NC
D7560	SINUSOTOMY-REMOVE TOOTH FRAGMENT	NC
D7610	MAXILLA OPEN REDUCTION	NC
D7620	MAXILLA CLOSED REDUCTION	NC
D7630	MANDIBLE OPEN REDUCTION	NC
D7640	MANDIBLE CLOSED REDUCTION	NC
D7650	FX SMPL MALAR/ZYG OPEN REDUCTION	NC
D7660	FX SMPL MALAR/ZYG CLOSED REDUCTION	NC
D7670	FRACTURED ALVEOLUS CLOSED REDUCTION	NC
D7671	ALVEOLUS/OPEN REDCTN INC STABLIZNG TH	NC
D7680	FX COMPLEX FACIAL BONES	NC
D7710	FRACTURE:MAXILLA OPEN REDUCTION	NC
D7720	FRACTURE:MAXILLA CLOSED REDUCTION	NC
D7730	FRACTURE:MANDIBLE OPEN REDUCTION	NC
D7740	FRACTURE:MANDIBLE CLOSED REDUCTION	NC
D7750	FX COMPOUND MALAR/ZYG OPEN REDUCTION	NC
D7760	FX COMPOUND MALAR/ZYG CLOSED REDUCTION	NC
D7770	FRACTURED ALVEOLUS - OPEN REDUCTION	NC
D7771	ALVEOLUS/CLOSED REDCTN STABLIZNG TH	NC
D7780	FX COMPOUND FACIAL BONES	NC
D7810	OPEN REDUCTION OF DISLOCATION	NC
D7820	CLOSED REDUCTION OF DISLOCATION	NC
D7830	MANIPULATION UNDER ANESTHESIA	NC
D7840	CONDYLECTOMY	NC
D7850	SURGICAL DISCECTOMY;WITH/WITHOUT IMPLANT	NC
D7852	DISC REPAIR	NC
D7854	SYNOVECTOMY	NC
D7856	MYOTOMY	NC
D7858	JOINT RECONSTRUCTION	NC
D7860	ARTHROTOMY	NC
D7865	ARTHROPLASTY	NC
D7870	ARTHROCENTESIS	NC
D7871	NON-ATHROSCOPIC LYSIS & LAVAGE	NC
D7872	ARTHROSCOPY-DIAGNOSIS, WITH/WITHOUT BIOP	NC
D7873	ARTHROSCOPY-SURGICAL:LAVAGE/LYSIS ADHES	NC
D7874	ARTHROSCOPY-SURGICAL:DISC REPOSITIONING	NC
D7875	ARTHROSCOPY-SURGICAL:SYNOVECTOMY	NC
D7876	ARTHROSCOPY-SURGICAL:DISCECTOMY	NC
D7877	ARTHROSCOPY-SURGICAL:DEBRIDEMENT	NC
D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT	NC
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	NC
D7899	UNSPECIFIED TMD THERAPY,BY REPORT	NC
D7910	SIMPLE WOUND TO 5 CM. SUTURES	NC
D7911	SUTURE WOUND TO 5 CM. COMPLICATED	NC
D7912	SUTURE WOUND > 5 CM COMPLICATED	NC
D7920	GRAFT SKIN	NC
D7921	COLLECT/APPLIC OF AUTOLOG BLOOD CONC PROD	NC
D7940	MANDIBULAR OSTEOPLASTY	NC
D7941	MAXILLARY OSTEOPLASTY	NC
D7943	OSTEOTOMY RAMUS OPEN WITH BONE GRAFT	NC
D7944	OSTEOTOMY SEGMENTED PER QUAD/SEXTANT	NC
D7945	OSTEOTOMY BODY OF MANDIBLE	NC
D7946	LEFORT I MAXILLA TOTAL	NC
D7947	LEFORT I MAXILLA SEGMENTED	NC
D7948	LEFORT II OR III WITHOUT BONE GRAFT	NC
D7949	LEFORT II OR III WITH BONE GRAFT	NC
D7950	GRAFT OSTEO PERIOSTEAL	NC
D7951	SINUS AUGMENTATION, LATERAL APPROACH	NC
D7952	SINUS AUGMENTATION VIA VERTICAL APPROACH	NC
D7953	BONE REPL GRAFT FOR RIDGE PRESERVATION	NC
D7955	REPAIR OF MAXI-FAC SOFT AND/OR HARD TIS DEF	NC
D7960	FRENECTOMY	173.95
D7963	FRENULOPLASTY	173.95
D7970	EXCISE HYPERPLASTIC TISSUE ARCH	SC
D7971	EXCISION PERICORONAL TISSUE	177.63
D7972	SURGICALLY REDUCE FIBROUS TUBEROSITY	SC
D7980	SIALOLITHOTOMY	NC
D7981	EXCISE SALIVARY GLAND	NC
D7982	SIALODOCHOPLASTY	NC
D7983	CLOSURE SALIVARY FISTULA	NC
D7990	EMERGENCY TRACHEOTOMY	NC

Procedure Code	Procedure Description	Current Allowance	Procedure Code	Procedure Description	Current Allowance
D7991	CORONOIDECTOMY	NC	D9243	15 MIN INTRAVENOUS IV MODER/CONSCIOUS	132.30
D7995	SYNTHETIC GRAFT,MANDIBLE OR FACIAL BONES	NC	D9248	NON INTRAVENOUS CONSCIOUS SEDATION	NC
D7996	IMPLANT,MANDIBLE FOR AUGMENTATION	NC	D9310	CONSULT:SPECIALIST	NC
D7997	APPLIANCE REMOVAL INCL REM OF ARCHBAR	NC	D9410	HOUSE CALLS	52.85
D7998	INTRAORAL PLACEMENT OF FIXATION DEVICE	NC	D9420	HOSPITAL CALLS INPATIENT	52.85
D7999	UNSPECIFIED ORAL SURGERY PROCEDURE	SC	D9430	OFFICE VISIT REGULAR HOURS	NC
D8010	LIMITED ORTHO. TRTMNT PRIMARY DENTITION	*	D9440	OFFICE VISIT AFTER HOURS	NC
D8020	LIMITED TRTMNT TRANSITIONAL DENTITION	*	D9450	CASE PRESENTATION	NC
D8030	LIMITED TRTMNT ADOLESCENT DENTITION	*	D9610	THERAPEUTIC DRUG INJECTION, BY REPORT	NC
D8040	LIMITED ORTHO TRTMNT ADULT DENTITION	*	D9612	THERAPEUTIC PARENTERAL DRUGS	NC
D8050	INTERCEPTIVE TRMNT PRIMARY DENTITION	*	D9630	OTHER DRUGS AND/OR MEDICAMENTS	NC
D8060	INTERCEPTIVE TRTMNT TRANSITIONAL DENT	*	D9910	DESENSITIZING MEDICATION APPLICATION	NC
D8070	COMPREHENSIVE TRTMNT TRANSITIONAL DENT	*	D9911	APPL OF DESENSITIZING RESIN CERVIC/ROOT	NC
D8080	COMPREHENSIVE TRTMNT ADOLESCENT DENT	*	D9920	BEHAVIOR MANAGEMENT	NC
D8090	COMPREHENSIVE TRTMNT ADULT DENTITION	*	D9930	TREATMENT:POST SURGICAL COMPLICATIONS	NC
D8210	APPLIANCE HABIT CONTROL REMOVABLE	*	D9932	CLEANING REMOVABLE COMPLETE DENT MAX	NC
D8220	FIXED APPLIANCE THERAPY HABIT CONTROL	*	D9933	CLEANING REMOVABLE COMPLETE DENTURE, MAND	NC
D8660	PRE-ORTHODONTIC TREATMENT VISIT	*	D9934	CLEANING REMOVABLE PARTIAL DENTURE, MAX	NC
D8670	PERIODIC ORTHODONTIC TRTMNT VISIT	*	D9935	CLEANING REMOVABLE PARTIAL DENTURE, MAND	NC
D8680	ORTHODONTIC RETENTION,APPLIANCE REMOVAL	*	D9940	OCCLUSAL GUARD BY REPORT	SC
D8681	REMOVABLE ORTH RETAINER ADJUST	NC	D9941	ATHLETIC MOUTHGUARDS	NC
D8690	ORTHODONTIC TRTMNT(ALTERNATIVE BILLING)	*	D9942	REPAIR AND/OR RELINE OF OCCLUSAL GUARD	SC
D8691	REPAIR OF ORTHODONTIC APPLIANCE	*	D9943	OCCLUSAL GUARD ADJUSTMENT	NC
D8692	REPLACEMENT OF LOST OR BROKEN RETAINER	NC	D9950	OCCLUSIONAL ANALYSIS	NC
D8693	REPAIR, AS REQUIRED, OF FIXED RETAINERS	*	D9951	OCCLUSAL ADJMNT LIMITED,ONE OR TWO TEETH	35.53
D8694	REPAIR OF FIXED RETAINERS, INCLUDES REATTACHMENT	165.38	D9952	OCCLUSAL ADJMNT COMPLETE	NC
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE	SC	D9970	ENAMEL MICROABRASION	NC
D9110	EMERGENCY PALLIATIVE TREATMENT	44.00	D9971	ODONTOPLASTY 1-2 TEETH INCL REM ENAMEL	NC
D9120	FIXED PARTIAL DENTURE SECTIONING	NC	D9972	EXTERNAL BLEACHING PER ARCH, PERFORM IN OFFICE	NC
D9210	ANES:LOCAL INDEPENDENT OF OPERATIVE PROC	NC	D9973	EXTERNAL BLEACHING PER TOOTH	NC
D9211	REGIONAL BLOCK ANESTHESIA	NC	D9974	INTERNAL BLEACHING PER TOOTH	NC
D9212	TRIGEM DIVISION BLOCK	NC	D9975	EXTERNAL BLEACHING FOR HOME, PER ARCH	NC
D9215	LOCAL ANESTHESIA	NC	D9985	SALES TAX	NC
D9219	EVAL FOR DEEP SEDATION OR GENERAL ANESTHESIA	NC	D9986	MISSED APPOINTMENT	NC
D9223	15-MIN DEEP SEDATION GENERAL ANESTHESIA	132.30	D9987	CANCELLED APPOINTMENT	NC
D9230	ANALGESIA	NC	D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE	SC

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NC = Not covered. Patient is liable for charge.

SC = Special consideration. Submit charge with a narrative and usual fee. Coverage and allowance will be determined by the dental consultant.

Benefits for services listed in this Schedule of Allowances are subject to coverage under members' dental plan.

The allowances specified in this schedule are not intended to represent what the dentist's charge will or should be, but merely show the maximum amount that will be considered as covered dental expenses. Dentists should submit their usual charge for covered and non-covered services.

* Orthodontic services are covered as a Class IV Benefit, subject to the deductible and lifetime maximum for dependents to age 19. The patient is responsible for the deductible, copayment and any balance exceeding the lifetime maximum. Please Note: Not all plans include an orthodontic benefit.

APPENDIX B

Excellus Summary of Benefits

Excellus

Dental Blue Options Summary of Benefits

Employer Group name: Rochester City School Disctrict
Plan Type: Contributory (employer-sponsored) Product Type: Passive PPO (same coinsurance in & out-of-network)

MAIN PLAN

Plan Features

Network: BlueShield local network	Dependent / student age limit: 23/26
Reimbursement In network/Participating: Fee Schedule Reimbursement Out-of-network/Non-Participating: Fee Schedule, subject to balance billing	
Annual Plan Deductible: $0 Ind / $0 Fam Deductible applies to: Classes II, IIA and III services	Annual Plan Maximum per member: $1,300 per member Annual Max applies to: Classes II, IIA and III services
Ortho Age Limit: Children to age 19 Lifetime Orthodontia Maximum: $2,100 per member (does not apply toward annual plan maximum)	

Plan Benefits

Type of Care	Benefits Included	Excellus BCBS Pays: In-Network	Excellus BCBS Pays: Out-of-Network*
Class I Preventive & Diagnostic	• Cleanings & exams - twice per cal year • Fluoride treatments – twice per cal year to age 19 • Sealants – unrestored 1st and 2nd permanent molars, once every 36 months • Bitewing x-rays – up to 4 every cal year • Full mouth / panorex x-rays – once every 36 months • Space maintainers – up to age 19 • Emergency palliative treatment	100%	100%
Class II Basic Restorative	• Fillings – amalgam & composite; each surface covered once every 12 months • Oral surgery – simple extractions	100%	100%
Class IIA Basic Restorative	• Oral surgery – surgical extractions • Endodontics – root canal treatment • Periodontal surgery – osseous surgery, gingivectomy, gingival flap procedure – covered once per quadrant every 36 months • Periodontal scaling & root planing – 5 Treatments per year • Periodontal maintenance following surgery – twice per cal year	100%	100%

This is not a contract or binding agreement; it is a summary of benefits and services. For complete details, please refer to your member contract.

*Out-of-Network/Non-Participating claims may be subject to balance billing

Type of Care	Plan Benefits	In-Network	Out-of-Network *
Class III Major Restorative	• Fixed prosthetics – bridgework, abutments, pontics • Removable prosthetics – partial / complete dentures • Inlays / onlays / crowns – includes coverage for re-cementation • Relines / rebases – once every 36 months and at least 6 months following initial placement • Above services eligible for replacement every 5 years • Implants – eligible for replacement every 10 years, and subject to alternate benefits provision	100%	100%
Class IV Orthodontia	• Initial banding & monthly follow-up treatment	100%	100%

How to Get The Most From Your Plan

Pre-determination of Benefits
Pre-determination of benefits is recommended for any extensive treatment such as periodontics, orthodontics or prosthetics. A description of planned treatment and expected charges should be sent to the Plan before treatment is started. If there is a major change in the treatment, a revised predetermination of benefits is required. The expenses that will be included as Covered Expenses will be determined by your Plan and are subject to the Alternate Benefit provision. When there has not been a predetermination of benefits, your Plan will determine the expenses that will be included as Covered Expenses at the time the claim is received. Predetermination of Benefits does not guarantee payment and expires one year from date of issue. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

Alternate Benefits Provision
All covered procedures are subject to an alternate benefit allowance. When there is more than one technology or material type for a dental procedure, the dental plan will reimburse for the procedure which has the lesser allowance. When alternate benefit is enforced, your benefits are not intended to interfere with the treatment plan recommended by the dentist. You and your dentist should discuss which treatment is best suited for you, and may proceed with the original treatment plan regardless of benefit determination. If the more expensive treatment is chosen, you are liable for the balance up to the billed amount.

Participating/In-Network Dentists
Excellus BlueCross BlueShield offers a broad participating dental network in the Rochester, Syracuse, Utica and surrounding areas.
You have the option of receiving care from a dentist of your choice. However, choosing a participating dentist may result in savings for you because participating dentists agree to accept our Schedule of Allowances as payment in full for covered services. Aside from any coinsurance, there is no balance billing for covered services when provided by a participating dentist – that's full coverage with no out-of-pocket expense for your covered routine preventive and diagnostic services.

Non-participating/Out-of-Network Dentists
You have the freedom to see any dentist. Non-participating dentists are not obligated to accept our Schedule of Allowances. You will be responsible for balances of non-participating dentists' charges.

Dental Customer Service – for members and dentists
1-800-724-1675
Hours: Monday – Thursday 8:00 am – 5:00 pm
Friday 9:00 am – 5:00 pm

Mailing address for claims
Excellus BCBS
P.O. Box 22999
Rochester, NY 14692

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Excellus

Dental Blue Options Summary of Benefits

Employer Group name: Rochester City School Disctrict
Plan Type: Contributory (employer-sponsored)
Product Type: Passive PPO (same coinsurance in & out-of-network)

CAFETERIA PLAN

Plan Features

Network: BlueShield local network	Dependent / student age limit: 19/23
Reimbursement In network/Participating: Fee Schedule Reimbursement Out-of-network/Non-Participating: Fee Schedule, subject to balance billing	
Annual Plan Deductible: $50 Ind / $100 Fam Deductible applies to: Classes II, IIA, III and IV services	Annual Plan Maximum per member: $1,000 per member Annual Max applies to: Classes II, IIA and III services
Ortho Age Limit: Children to age 19 Lifetime Orthodontia Maximum: $1,000 per member (does not apply toward annual plan maximum)	

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Class II Basic Restorative	• Fillings – amalgam & composite; each surface covered once every 12 months • Oral surgery – simple extractions	80%	80%
Class IIA Basic Restorative	• Oral surgery – surgical extractions • Endodontics – root canal treatment • Periodontal surgery – osseous surgery, gingivectomy, gingival flap procedure – covered once per quadrant every 36 months • Periodontal scaling & root planing – 5 treatments per year • Periodontal maintenance following surgery – twice per cal year	80%	80%

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Class III Major Restorative	• Fixed prosthetics – bridgework, abutments, pontics • Removable prosthetics – partial / complete dentures • Inlays / onlays / crowns – includes coverage for re-cementation • Relines / rebases – once every 36 months and at least 6 months following initial placement • Above services eligible for replacement every 5 years • Implants – eligible for replacement every 10 years, and subject to alternate benefits provision	50%	50%
Class IV Orthodontia	• Initial banding & monthly follow-up treatment	50%	50%

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