Dental Plan: City of Rochester

2016 Summary of Benefits

Coverage Period: 01/01/2016 – 12/31/2016

Coverage for: All Tiers | **Plan Type:** Dental

*The following summarizes **what you pay** for covered services and the maximum benefit for this plan. For exact terms and conditions, refer to your plan document for a detailed list of the plan's benefit limitations and exclusions*

1. Annual Deductible	
	$25 per member; $75 per family
2. Calendar Year Maximum Benefit	
Includes all class expenses combined.	Limit of $1,050 benefit paid by the plan per member
3. Preventive Expenses (Class A)	
■ X-rays performed by a dentist or orthodontist, including panoramic X-rays limited to once per 24-month period, bitewing X-rays limited to once per 5-month period and other X-rays necessary to diagnose a dental condition or evaluate progress, including periapical, occlusal and full-mouth X-rays ■ Prophylaxis (cleaning, scaling and polishing) limited to once per 5-month period ■ Topical application of fluoride for dependent children under age 19 limited to one treatment per 5-month period ■ Applications of sealants on posterior teeth (molars) for children under age 14 limited to once in a period of 3 years ■ Examinations for consultation purposes ■ Lab tests (oral pathology) ■ Routine oral examinations limited to once per 5-month period	0% - no deductible
4. Basic Expenses (Class B)	
■ Emergency palliative treatment, including the exam ■ Space maintainers for missing deciduous teeth, including all adjustments within 6 months after installation ■ Injections of antibiotic ■ Desensitizing medications ■ Tooth extractions, including impactions ■ Administration of general anesthesia and/or intravenous sedation ■ Analgesia ■ Oral surgery, including reconstructive when service is coinciding with or follows surgery resulting from an illness or other disease of involved part ■ Amalgam, acrylic, composite or equivalent filling restoration for decayed teeth ■ Stainless steel crowns for deciduous teeth only, including repairs ■ Endodontic treatment, including pulp capping, pulpotomy (deciduous teeth only) and root canal therapy ■ Treatment of periodontal disease, including prophylaxis, scaling/root planing and periodontal surgery	40% after deductible

5. Major Expenses (Class C)	
■ Gold foil restorations ■ Inlays and onlays ■ Installation of crowns, including post and core or crown build-up when there is insufficient tooth structure to hold the crown ■ Temporary crowns ■ Necessary replacement of crowns, only when the crown is over five (5) years old ■ Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace teeth ■ Temporary bridges ■ Pins and posts for bridgework and crowns ■ Repair or recementing of crowns (other than pre-formed stainless steel crowns), inlays or onlays ■ Initial installation of dentures ■ Adjusting, relining or rebasing of dentures ■ Temporary partials and/or dentures ■ Tissue conditioning ■ Overdentures ■ Necessary repair of dentures or bridgework ■ Replacement of an existing partial or full removable denture or fixed bridgework; the addition of teeth to an existing partial or removable denture; or bridgework to replace teeth which were extracted if satisfactory evidence is presented to the plan	40% after deductible

The City of Rochester Employee Dental Benefit Plan is administered by Mayo Clinic Health Solutions, a subsidiary of Mayo Clinic, operating under contract to the City of Rochester. If there are any inconsistencies between this document and the plan documents, the plan documents will be relied upon for plan administration and will govern the benefits available. If you have any questions about the plan, please contact Mayo Clinic Health Solutions Customer Service toll-free at 1-800-771-9215 or 284-2412.

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