



**Summary of Dental Insurance Benefits for Employees of Columbia University for Non-Union Support Staff, UAW Local 2110 Members, TWU Local 241 Members, and Supporting Staff Association Members**

**Preferred Dental**

When you choose **GHI Preferred Dental**, you have the **freedom to choose** which dentists or other dental care providers you use for most covered services. With **GHI**, you **are not required** to choose a specific primary care dentist, and generally you decide if you want to receive covered services from participating Preferred network providers or non-participating providers. All benefits shown below are on a per person basis.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Type A – Preventive and Diagnostic Services</b>		
<b>Base Coverage Level</b>	Covered in Full (Provider accepts 100% of the Preferred Schedule of Allowances as payment in full)	GHI reimburses you up to 100% of the Spectrum Allowance. You are responsible for any dental charges that exceed this payment.
<b>Examinations</b> – 2 per calendar year. – 1 initial comprehensive examination per dentist, per lifetime.	Covered in Full	Base Out-of-Network Coverage
<b>Cleanings (Prophylaxes)</b> – 2 per calendar year.	Covered in Full	Base Out-of-Network Coverage
<b>X-Rays</b> – 4 bitewing x-rays per calendar year. – 1 full-mouth series of x-rays or 1 panoramic film once every 3 years.	Covered in Full	Base Out-of-Network Coverage
<b>Fluoride Treatments</b> – 1 per calendar year per dependent child. Coverage provided until end of calendar year child reaches age 19.	Covered in Full	Base Out-of-Network Coverage
<b>Space Maintainers</b> – 1 per dependent child, per lifetime. Coverage provided until end of calendar year child reaches age 19.	Covered in Full	Base Out-of-Network Coverage
<b>Mouth Guards</b> – 1 per dependent child, per lifetime. Coverage provided until end of calendar year child reaches age 19.	Covered in Full	Base Out-of-Network Coverage
<b>Sealant</b> – Every 3 years for dependent child to age 14. Coverage provided until end of calendar year child reaches ages 14.	Covered in Full	Not Covered
<b>Type B – Basic Services</b>		
<b>Base Coverage Level</b>	Covered in Full (Provider accepts 100% of the Preferred Schedule of Allowances as payment in full)	GHI reimburses you up to 100% of the Spectrum Allowance. You are responsible for any dental charges that exceed this payment.
<b>Extractions</b>	Covered in Full	Base Out-of-Network Coverage
<b>Basic Restorations (Fillings)</b> – Posterior composite fillings are reimbursed at the amalgam fee.	Covered in Full	Base Out-of-Network Coverage
<b>Endodontics (Root Canal Therapy)</b> – Pulpotomy covered once per tooth, per lifetime. Not covered if root canal therapy done on same tooth by same provider within prior 3 months.	Covered in Full	Base Out-of-Network Coverage
<b>Periodontics (Treatment of Diseases of the Gum and Jaw)</b> – 5 periodontal treatments per calendar year. – 1 type of periodontal surgery and/or 1 graft per quadrant.	Covered in Full	Base Out-of-Network Coverage
<b>Oral Surgery (Surgical Removal of an Erupted Tooth)</b> – Charges for x-rays taken solely for surgery, local anesthesia, and post-operative care included in allowance for oral surgery. – Coverage includes surgery on fractured jaws, impactions, lesions in and around the mouth, and reimplantations.	Covered in Full	Base Out-of-Network Coverage

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Type B – Basic Services</b>		
<b>Anesthesia and IV Sedation</b> – Covered for general anesthesia and IV sedation for covered surgical services. Charges for local anesthesia are included in the allowance for the dental procedure. No separate allowance for local anesthesia. Analgesia and monitoring devices not covered.	Covered in Full	Base Out-of-Network Coverage (Excludes IV Sedation)
<b>Palliative Services (Relief of Pain)</b> – 1 service per calendar year, emergencies only.	Covered in Full	Base Out-of-Network Coverage
<b>Repair of Appliances (Dentures)</b> – Replacement of broken teeth or clasps, recementation of inlays, crowns, bridges and space maintainers. Replacement of broken facings.	Covered in Full	Base Out-of-Network Coverage
<b>Tests and Laboratory Exams</b> – Biopsy and examination of oral tissue.	Covered in Full	Base Out-of-Network Coverage
<b>Type C – Major Services</b>		
<b>Base Coverage Level</b>	Covered in Full (Provider accepts 100% of the Preferred Schedule of Allowances as payment in full)	GHI reimburses you up to 100% of the Spectrum Allowance. You are responsible for any dental charges that exceed this payment.
<b>Prosthetics (Dentures, Bridges, Crowns, and Inlays)</b> – Both immediate and permanent dentures, full or partial, repair, and crowns over implants. – In-Network Preferred allows replacement or substitution of appliances only after 5 years since appliance was inserted. – Coverage provided for crowns or pontics for attachment or clasp purposes (fixed bridgework) only if tooth cannot be restored by fillings. – Denture rebase, chairside reline or duplication (jump) limited to 1 per denture in a 3-year period. – Rebase or repair of new dentures covered only after 6 months from insertion date of the denture. – When a fixed bridge and partial denture are inserted in same arch, only the partial denture is covered unless 5 years have passed since prior insertion of fixed bridge or partial denture. – No separate allowance for temporary service or appliance. – Crowns over implants are reimbursed based upon the allowance for a single crown, porcelain fused to predominantly base metal. The patient is responsible for the difference between the dentist's normal submitted fee and the GHI payment amount.	Covered in Full	Base Out-of-Network Coverage
<b>Major Restorative</b> – Includes crowns, related post and core procedures and inlays. – Crowns and inlays covered only when used as primary support for fixed appliances. – Posts covered only if there is evidence of root canal on the tooth. – Charges for cementation of crown/inlay is included in allowance for the crown/inlay.	Covered in Full	Base Out-of-Network Coverage

**Dependent Coverage:** Children are eligible for coverage until the end of the calendar year in which they reach age 19.

**Annual Deductible:** None.

**Annual Maximum:** \$1,200 per person.

**Predetermination of Benefits:** This is a process by which GHI reviews and estimates benefits before services are rendered. It helps you to know in advance which services and materials GHI will cover or the benefits GHI will provide. It is available upon request for certain services. It is not available for Type A or Type B basic restorative services such as extractions, fillings, root canal therapy, treatment of gum disease, etc. To obtain a Predetermination of Benefits, submit a Treatment Plan to GHI before receiving oral surgery, prosthetics or appliances. GHI will review the Treatment Plan and inform you and your provider of the results. The estimate may change based upon any new information received by GHI after it has issued the Predetermination of Benefits. If the services actually rendered are not the services set forth in the proposed treatment plan, then this Predetermination of Benefits shall be void.

**Dental Services Not Covered:** In addition to other exclusions, this program provides no coverage for: orthodontics, implants, transplants, cosmetic surgery and treatment unless otherwise medically necessary, prescription drugs and medications, services and appliances for the treatment of temporo-mandibular joint (TMJ) dysfunction, behavioral management, and other services not listed as covered. You are not covered for services that do not conform to accepted standards of dental practice.

Policy form # PLD-1081B, et. al.

**NOTE:** *This is not a complete benefits comparison or a contract, and should only be viewed as a brief summary to assist you in understanding this GHI benefits program. A detailed benefits description, including limitations and exclusions, is contained within the Certificate of Insurance. The terms, conditions, limits and exclusions shown in the Certificate of Insurance shall govern.*

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