



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

**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 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, end of calendar year.	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 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 100% of the Spectrum Allowance. You are responsible for any dental charges that exceed this payment.
<b>Prosthetics (Dentures)</b> – Both immediate and permanent dentures, full or partial, repair, and crowns over implants. – In-Network Preferred Plus 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.

**Dental Services Not Covered:** In addition to other exclusions, this program provides no coverage for: orthodontics, 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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**GROUP HEALTH INCORPORATED**

(hereinafter referred to as "GHI")  
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**GHI DENTAL  
CERTIFICATE OF INSURANCE**

This Policy provides DENTAL insurance only to the extent limited and defined in this Certificate and the Attachment. The Certificate and Attachment are evidence of the benefits provided by the Group Contract to which this Certificate relates during the time a person is insured thereby.

**GROUP HEALTH INCORPORATED**

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## ARTICLE ONE - INTRODUCTION

**1. Your Coverage under This Policy.** Your group has entered into a Group Contract with Group Health Incorporated (“GHI”) to provide you and your covered dependents with dental insurance benefits. Under this Group Contract, GHI will provide dental benefits to Members.

This booklet is your Certificate of Insurance. Together with the Attachment, it evidences your coverage under the Group Contract. It is not a contract between you and GHI. You should keep this booklet and the Attachment with your other important papers so that it is available for your future reference.

The Attachment provides important information about the nature and extent of your dental coverage. It sets forth:

- The dental services that GHI will cover under this Policy.
- The deductibles, if any, that apply to your coverage.
- The Schedule(s) of Allowances and the other payment terms that apply to covered services.
- The annual maximums that apply to your coverage.
- The limiting ages for coverage of dependent children and dependent students.
- And any lifetime maximums that may apply to your coverage.

This Policy covers only the types of dental services listed as “covered” in the Attachment. The types of dental services that may be covered are described in this booklet. Coverage is subject to all terms, conditions, limitations and exclusions set forth in this Certificate and the Attachment, and the Group Contract.

GHI’s payments for covered services are usually based upon a Schedule of Allowances. Payments for covered, but unlisted procedures will be made in a manner consistent with those for listed procedures.

You may obtain a Predetermination of Benefits from GHI in connection with certain services. Please be sure to review Article Five of this booklet before you receive any dental services.

**2. Criteria for Coverage.** The fact that your physician or dentist prescribed or provided care does not automatically mean that the care qualifies for payment by GHI. GHI will provide benefits only for the services that are listed as “covered” in the Attachment and described in this Policy. GHI will cover such services only if they are medically necessary and not otherwise excluded under this Policy. A Provider must also render the services, and the services must be within the scope of the Provider’s license. The Dentist or Provider must also have a license or certification to perform the service(s) in the jurisdiction where the service(s) is rendered. Other conditions for coverage may apply to specific covered services. These other conditions are set forth in the specific benefit descriptions in the articles that follow.

Medically necessary services are dental services that are found by GHI to meet all of the criteria listed below.

- They are provided for the diagnosis, or direct care or treatment of the condition, illness, disease, injury or ailment.
- They are consistent with the symptoms or proper diagnosis and treatment of the medical condition, disease, injury or ailment.
- They are in accordance with accepted standards of good dental practice in the community.
- They are furnished in a setting commensurate with the patient’s medical needs and condition.
- They cannot be omitted under the standards referenced above.
- They are not in excess of the care indicated by generally accepted standards of good dental practice in the community.
- They are not furnished primarily for the convenience of the patient, the patient’s family or the Provider.

Review for medical necessity is performed under the supervision of GHI's Medical Director. A clinical peer reviewer will confirm each finding by GHI that a service is not medically necessary or that a service is experimental or investigational and, therefore, not covered. GHI may require you or your Provider to furnish a statement to detail the nature and necessity of a rendered service. This statement must be provided in order for you to be eligible to receive benefits. It must be in a form acceptable to GHI.

This dental insurance policy does not require you to obtain prior-authorization from GHI for any covered dental services. However, GHI may perform a retrospective review of your claim(s) to determine medical necessity and eligibility for coverage.

You, your Provider or your designated representative must file a claim form with GHI in order to request dental benefits. GHI will notify you in writing of its decision on your claim within thirty (30) days of GHI's receipt of the claim(s). If GHI requires more information to decide your claim, GHI will request such information within fifteen (15) days after its receipt of the claim. GHI will give you at least forty-five (45) days to supply the information. GHI will notify you of its decision on the claim within fifteen (15) days after GHI's receipt of all or part of the information or within fifteen (15) days after the end of the time period GHI gives you to supply the information. If the medical necessity or the experimental nature of the services is not in question, GHI may combine its request for information with a notice of denial. If GHI does not receive the information requested, then this denial will apply. In such a case, you will not receive a further notice from GHI at the end of the time period that GHI gives you to supply the information.

If you disagree with GHI's decision on a claim, you may file a grievance or an appeal requesting that GHI reconsider its decision. Please see the section entitled "Filing of Claims, Grievances and Appeals" for information about how to file grievances and appeals with GHI.

In all instances GHI reserves the right to determine benefits, taking into account alternate procedures, services or courses of treatment.

## **ARTICLE TWO - DEFINITIONS**

**1. Allowed Charge.** Allowed Charges are fee profiles that GHI uses to reimburse covered services received from Non-Network Providers. The Attachment will tell you whether you have benefits for dental services received from Non-Network Providers, and if so, it will also tell you whether GHI will reimburse you for such services based upon a Schedule or based upon an Allowed Charge. GHI develops its Allowed Charges using charge data based upon a percentile of the Ingenix/Health Insurance Association of America Health Care Charges System (Ingenix/HIAA-PHCS). The Ingenix/HIAA-PHCS percentile is selected by your group and it is set forth on the Attachment. GHI will update its Ingenix/HIAA-PHCS data once per year. GHI may, in its discretion, modify or update its Allowed Charges at any time. GHI's Allowed Charges may not reflect actual Ingenix/HIAA-PHCS charges for a particular covered service in a particular geographic area, and may instead reflect a GHI determined regionally blended amount. For services rendered outside of New York, GHI will develop its Allowed Charges using the Ingenix/HIAA-PHCS data for an area selected by GHI within New York. If your Provider's actual and customary billed charge is less than the Allowed Charge, GHI will consider your Provider's charge the Allowed Charge for that claim.

There may be occasions where GHI does not have an Allowed Charge for a particular service. When this is the case, GHI will make payment based upon the Relative Value Scale to determine comparability between procedures. The Relative Value Scale is a standard of rating generally accepted in the health insurance field.

**2. Attachment.** Attachment means the attachment to this Certificate. It provides important information about the nature and extent of your dental coverage. It sets forth the types of dental services that GHI will cover. It also sets forth the payment terms that apply to covered services. It advises you whether or not you are covered for covered services rendered

by Network and/or Non-Network Providers. It sets forth the annual and lifetime maximums that apply to your coverage. It also sets forth the limiting ages for coverage of dependent children and dependent students.

**3. Certificate.** This document is a Certificate of Insurance.

**4. Group Contract.** The Group Contract is the agreement GHI has with your group.

**5. Late Entrant.** A late entrant is any person whose effective date of coverage under this Policy is more than thirty (31) days from the date the person qualifies for the coverage, or who has elected to become insured again after canceling a premium contribution agreement.

**6. Member.** A Member is a Subscriber. It may also be a person who is eligible for coverage under this Policy by reason of a family relationship to the Subscriber, and has been added to the Policy by the Subscriber. Each Member other than the Subscriber must be a person described below.

(a) **Spouse.** He or she must be the spouse of the Subscriber. An ex-spouse is not eligible for coverage regardless of the terms of any settlement agreement. The submission of a claim by or for an ex-spouse under this policy is an insurance fraud.

(b) **Unmarried, Dependent Child.** He or she must be an unmarried, dependent child of the Subscriber under the age set forth in the Attachment. A dependent that is not the natural child of the Subscriber may also be eligible for coverage. An adoptive child or stepchild is eligible for coverage. The child must be dependent upon the Subscriber for support, or the subscriber must have assumed legal responsibility in place of the parent. A dependent adoptive child will be covered on the same basis as a natural child during any waiting period prior to finalization of the adoption. An adoptive child is covered at the earliest of the dates set forth below.

(i) Upon the filing of an adoption petition. A proposed adoptive child will be covered as of the first day of the waiting period prior to the finalization of the adoption.

(ii) A court of law accepts a consent to adopt and you enter into an agreement to support the child.

(iii) An adoptive newborn is covered from the moment of birth for injury or sickness. The Subscriber must take physical custody of the newborn upon the newborn's release from the hospital. The Subscriber must also file a petition for adoption or an application for temporary guardianship within thirty (30) days after the child's birth.

(c) **Unmarried, Dependent Child Incapable of Self-Sustaining Employment.** An unmarried, dependent child over the age set forth in the Attachment may also be eligible for benefits. The child must meet all of the conditions set forth below.

(i) He or she must be incapable of sustaining employment due to mental illness, developmental disability or mental retardation as defined in the New York State Mental Hygiene Law, or physical handicap.

(ii) He or she must have been so incapable before the age at which dependent coverage would otherwise terminate.

(iii) He or she must have been eligible for benefits before the age at which dependent coverage would otherwise terminate.

(iv) A physician must certify the child's condition.

(v) Proof of the condition is submitted to GHI within thirty-one (31) days of the date the dependent reaches the age at which dependent coverage would otherwise terminate.

GHI has the right to check whether a child is and continues to qualify as an unmarried, dependent child incapable of self-sustaining employment.

(d) **Unmarried Full-Time Dependent Student.** He or she must be an unmarried, dependent full time student under the age set forth in the Attachment. The student must be enrolled in an accredited educational institution. The institution must grant a degree or diploma. You must supply at least fifty percent (50%) of the student's support. Unmarried, dependent full time students are covered until they reach the limiting age set forth in the Attachment or until the end of the month in which they otherwise lose eligibility. An unmarried, dependent student will otherwise lose eligibility if he or she marries, loses dependent status or loses full time student status.

**7. Network Provider.** A Network Provider is any Dentist or Provider who has an agreement with GHI to accept GHI's Schedule of Allowances or a negotiated rate(s) as payment in full for covered dental services and who participates in the GHI provider network that applies to this Policy. GHI will pay a Network Provider directly for covered services. The Attachment will state whether or not GHI will provide benefits for covered services rendered by Network Providers. If you have benefits for covered services received from Network Providers, you will not have to make any payments, other than applicable deductibles and coinsurance charges, to a Network Provider for covered services. The Network Provider will file a claim form on your behalf.

**8. Non-Network Provider.** A Non-Network Provider is any Dentist or Provider who does not have an agreement with GHI to accept GHI's Schedule of Allowances or negotiated rate(s) as payment in full for covered dental services and/or who does not participate in the GHI provider network that applies to this Policy. The Attachment will state whether or not GHI will provide benefits for covered services rendered by a Non-Network Providers.

You must pay a Non-Network Provider's full bill. You must file a claim form with GHI in order to be eligible to receive benefits. If you are covered for services rendered by Non-Network Providers, GHI will issue payment for covered services rendered by a Non-Network Provider according to the terms set forth in this Certificate and the Attachment. GHI will pay benefits directly to you for covered services.

**9. Policy.** Policy refers to this Certificate, the Attachment and the underlying Group Contract.

**10. Predetermination of Benefits.** Predetermination of Benefits is a process whereby GHI estimates benefits before services are rendered. To obtain a Predetermination of Benefits, a Treatment Plan must be sent to GHI before certain services are performed. GHI will review the plan and send you an estimate of the benefits for covered services. (See Article Five.)

**11. Provider.** Provider means a dentist, a dental clinic or dental facility that is permitted to perform covered services. A dentist means a licensed dentist or physician who renders covered dental care. The dentist or physician must be licensed or certified to perform the service in the jurisdiction in which the service is rendered.

**12. Schedule of Allowances.** A Schedule of Allowances or "Schedule" is a set of allowances for covered services. The Schedule(s) of Allowances that applies to covered services rendered by Network Providers is identified on the Attachment. GHI will pay Network Providers for covered services based upon the Schedule(s) unless GHI has negotiated a separate rate(s) with the Provider. If GHI has a negotiated rate(s) with a Network Provider, then the Schedule of Allowances for that Provider refers to GHI's negotiated rate(s) with the Provider. GHI may also reimburse you for covered services rendered by Non-Network Providers based upon a Schedule of Allowances. However, if a Non-Network Provider's actual and customary billed charge is less than the Scheduled amount, then GHI will consider your Provider's charge the Scheduled amount for that claim. Please refer to the Attachment for information about how GHI will reimburse services received from Non-Network Providers. GHI's Schedules of Allowances may be amended from time to time. GHI's Schedules of Allowances are on file with the New York State Insurance Department. They are available for inspection at the offices of the New York State Insurance Department and at GHI's offices. In the event that the GHI Allowance for a covered service rendered exceeds the amount billed by the Dentist or Provider for that service, GHI will consider the Dentist or Provider's billed charge to be the Scheduled amount for that particular service.

**13. Subscriber.** A Subscriber is the person to whom this Policy is issued. He or she is insured by virtue of his or her membership in or employment by the group.

**14. Treatment Plan.** A Treatment Plan is a proposed detailed statement of the dental services to be rendered and the fees to be charged. To obtain a Predetermination of Benefits, you must submit a Treatment Plan to GHI before services are rendered. Based on the Treatment Plan, GHI will estimate your benefits.

**15. You.** In order to make this document easier to read, we have used the word “you” instead of Subscriber or Member in the text.

### **ARTICLE THREE – DENTAL SERVICES**

All of the various dental services that GHI may cover are described in this Article. The Attachment will tell you which of these dental services are actually covered under this Policy.

GHI will cover only those dental services that are specifically included on the Attachment as part of a service class or type that the Attachment indicates as “covered.” For example, if Type A – Preventive Services are listed in the Attachment as “covered”, and prophylaxes is listed in the Attachment as a component service of Type A - Preventive Services, then you have prophylaxes coverage, subject to the terms listed in the Attachment for Type A - Preventive Services. If prophylaxes is not listed among the dental services that are part of the types or classes of dental services that are listed as “covered” on the Attachment, then you do not have coverage for prophylaxes under this Policy even though prophylaxes is described in this Certificate.

The Attachment also tells you whether benefits are available for covered dental services received from Network Providers, Non-Network Providers, or both, and what payment terms apply.

You may obtain a Predetermination of Benefits from GHI for certain services. Please review Article Five of this Certificate before you receive any dental services.

The various dental services that GHI may cover follow below.

**Prophylaxes.** If prophylaxes is included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover prophylaxes. Prophylaxis is the scaling, cleaning and polishing of the teeth. GHI will cover only the number of prophylaxes set forth on the Attachment per Member per calendar year. Please refer to the portion of the Attachment entitled Special Benefit Limits for this number.

**Fluoride Treatments.** If fluoride treatments are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover fluoride treatment for dependent covered children. GHI will cover one (1) fluoride treatment per child per calendar year. Coverage is available for this service until the end of the calendar year in which the child reaches age nineteen (19).

**Examinations.** If examinations are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover routine examinations of the oral cavity. This includes charting of the teeth, if performed. GHI will cover the number of examinations set forth on the Attachment per person per calendar year. Please refer to the portion of the Attachment entitled Special Benefit Limits for this information. GHI will only cover one (1) initial comprehensive oral evaluation per Provider per lifetime. All subsequent non-emergency examinations done by the same provider are covered as periodic examinations.

**X-Rays.** If x-rays are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover the taking of x-ray films of the teeth, mouth or jaw. GHI will cover four (4) bitewing x-rays for each Member in each calendar year. GHI will cover the taking of fourteen (14) standard periapical x-ray films or one (1) panoramic film once every three (3) – five (5) years. GHI will also cover two (2) occlusal intra-oral x-ray films

within a three (3) year period. Individual periapical x-rays performed on the same day as a full mouth series are not covered. Duplication of x-rays is not covered.

**Biopsy & Examination of Oral Tissue.** If biopsy and examination of oral tissue are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover biopsy and examination of oral tissue. However, you are not covered for salivagraphy, temporo-mandibular joint (TMJ) arthrogram (including injection), tomographic survey, bacteriological studies, caries susceptibility, pulp vitality test, diagnostic casts and photographs.

**Space Maintainers.** If space maintainers are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover one (1) space maintainer per covered dependent child per lifetime. GHI covers the treatment and the appliance. GHI will cover space maintainers only until the end of the calendar year in which the child reaches age nineteen (19). If the insertion of a space maintainer is performed in conjunction with the re-cementation of a space maintainer, GHI’s allowance will be the scheduled amount for insertion of the space maintainer. GHI will not provide a separate allowance for the re-cementation.

**Mouth Guards.** If mouth guards are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover one (1) mouth guard per lifetime for each covered dependent child. The mouth guard must be for use in athletic activity. A Dentist must also prescribe it. Coverage is provided for this protective appliance only until the end of the calendar year in which the child reaches age nineteen (19).

**Palliative Services.** If palliative services are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover one (1) palliative service for each Member in each calendar year. This is a service for the relief of pain. You must have made an emergency visit to your Provider. This includes an adjustment of a prosthetic appliance that must have been installed for over one (1) year.

**Sealants.** If sealants are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover sealants for each covered dependent child between the ages of 6 through 14. GHI will only cover sealants applied to the occlusal (biting) surface of the first and second permanent molars and bicuspids. GHI will not cover sealants applied to other surfaces or teeth. Benefits are available once per covered tooth every three (3) calendar years.

**Basic Restorations.** If basic restorations are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover basic restorations. Basic restorations are fillings. GHI will not cover temporary fillings, sedative fillings, tissue conditioning and acid etch. Benefits are subject to the terms set forth below.

- The Schedule of Allowances imposes a maximum benefit for fillings done on the same tooth by the same Dentist or Provider within a six (6) month period. GHI will not pay more than this maximum benefit for fillings for each Member in any six (6) month period.
- If two (2) fillings are done on the same posterior tooth on the same day, GHI’s allowance will be up to the Scheduled or Allowed amount for a three (3) surface amalgam.
- If two (2) fillings are done on the same anterior tooth on the same day, GHI’s allowance will be up to the Scheduled or Allowed amount for three (3) composite fillings.
- If a three (3) surface inlay, crown or abutment is done on a tooth that has been filled within the last six (6) month period, GHI will deduct the Scheduled or Allowed amount for the filling from its payment for the inlay, crown or abutment.
- The allowance for a one (1) surface inlay will be the Scheduled or Allowed amount for a one (1) surface filling.

- If an onlay and inlay are done on the same tooth on the same day, GHI's allowance will be the Scheduled or Allowed amount for the inlay. A separate allowance for the onlay will not be provided.
- The allowance for composite resin inlays will be the Scheduled or Allowed amount for a filling.
- The charge for cementation for a crown/inlay is included in the allowance for the crown/inlay.

**Consultations.** If consultations are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover a consultation with a specialist. GHI will cover the consultation if there is no other service rendered by the specialist on that date or within one (1) month. If you have coverage for examinations, then a consultation will count as an examination toward the examination maximum per person per calendar year set forth on the Attachment. You cannot be referred by a Dentist who practices in the same office or in association with the specialist. The report of the specialist must be submitted with your claim form.

**Extractions.** If extractions are included in a type of dental service that is listed as “covered” on the Attachment, GHI will cover the routine removal of a tooth or teeth. GHI's allowance for the extraction includes pre-and post-operative x-rays, post-operative care and local anesthesia.

**Repair of Prosthetic Appliances.** If repair of prosthetic appliances is included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover the repair of dentures, the replacement of broken teeth or clasps in a denture, recementation of inlays, crowns, bridges and space maintainers and the replacement of broken facings. The Schedule of Allowances imposes an annual maximum benefit for all repairs. GHI will not pay more than the maximum benefit for each member in each calendar year for repairs.

- GHI will cover the replacement of broken teeth or clasps in a denture. GHI will also cover the recementation of bridges and the replacement of broken facings. The Schedule of Allowances imposes an annual maximum benefit for all repairs. GHI will not pay more than that maximum benefit for each Member in each calendar year for repairs.
- Duplication (Jump), rebase, or chairside relines to a denture is limited to one (1) per denture in a [five (5) – ten (10)] year period. This applies to both partial and full dentures.
- Rebase or repair of new dentures are covered only after six (6) months have passed after the date of the insertion of the denture.

**Bedside Calls.** If bedside calls are included in a type of dental service that is listed as “covered” in the Attachment, then GHI will cover bedside calls. The call must be made due to an emergency.

**Endodontics (Non-Surgical).** If endodontics (non-surgical) is included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover non-surgical endodontics. The guidelines below apply to your coverage for these services.

- Pulpotomy is covered once per tooth per lifetime. However, pulpotomy is not covered if root canal therapy was done on the tooth by the same Dentist or Provider within the prior three (3) month period.
- Pulp capping is not covered.
- Surgical replacement of rubber dam, recalcification of perforation, preparation of canal for posts or dowels, and bleaching of discolored teeth are not covered.

**Surgical Endodontics (Root Canal Therapy).** If surgical endodontics (root canal therapy) is included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover surgical endodontics. You may obtain a Predetermination of Benefits for certain surgical endodontics. (See Article Five). The guidelines below apply to your coverage for this service.

- If any combination of apicoectomy, root end amalgam and apical curettage is done on the same tooth by the same Provider within a three (3) month period of root canal therapy, GHI will not apply the Scheduled or Allowed amounts for these services. GHI will apply a combined allowance for these services.
- The allowance for incision and drainage done within two (2) weeks of root canal therapy or periodontal surgery on the same tooth by the same Provider will be deducted from the allowance for the root canal therapy or periodontal surgery.

**Oral Surgery.** If oral surgery is included in a type of dental service that is listed as “covered” in the Attachment, then GHI will cover oral surgery. You may obtain a Predetermination of Benefits for certain types of oral surgery. (See Article Five). GHI will cover the surgical removal of an erupted tooth. You are covered for surgical procedures in or about the oral cavity. X-rays taken solely for your surgery, local anesthesia and post-operative care are not separately covered. They are included in GHI’s allowance for oral surgery. The guidelines below apply to your coverage for this service.

- The Schedule of Allowances imposes an annual maximum benefit per arch for alveolectomy and alveoplasty. GHI will not pay more than that maximum benefit per arch for each Member in each calendar year for these services.
- Alveolectomy done in conjunction with a surgical extraction is not covered.
- Surgery on fractured jaws, impactions, and lesions in and around the mouth is covered. Orthognathic surgery and surgery relating to accidental injury are not covered.
- Implants and transplantations are not covered. Reimplantations are covered.

**Anesthesia & IV Sedation/Analgesia.** If anesthesia and IV sedation/analgesia are included in a type of dental service that is listed as “covered” in the Attachment, then GHI will cover anesthesia rendered in or out of a hospital. The anesthesia or IV sedation/analgesia must be rendered in connection with a covered service. As with all covered services, the services must be consistent with accepted standards of dental practice as well as GHI’s other criteria for medical necessity, and the services must be performed by a licensed provider certified to provide the anesthesia or IV sedation/analgesia by the state in which the services are rendered.

**Periodontal Surgery.** If periodontal surgery is included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover periodontal surgery, including soft tissue and osseous surgery. You may obtain a Predetermination of Benefits for certain periodontics. (See Article Five). GHI will cover five (5) periodontal treatments in each calendar year. You are covered for one (1) type of periodontal surgery and/or one (1) graft per quadrant. Five (5) single tooth periodontal surgeries or grafts are considered to be a quadrant. Periodontal appliances are not covered.

- Repeated periodontal surgeries or grafts will not be covered for a period of three (3) years from the date of the original surgery or graft.
- You are covered for guided tissue regeneration.

**Periodontal Treatment (Non-surgical).** If periodontal treatment (non-surgical) is included in a type of dental service that is listed as “covered” on the Attachment, GHI will cover non-surgical periodontics. Non-surgical periodontics is the treatment of diseases of the gums and the long structure of the jaw, including subgingival scaling, periodontal prophylaxis and minor bite correction (occlusal adjustment). You are covered for five (5) periodontal treatments in each calendar year. The guidelines below apply to your coverage.

- Occlusal adjustments done on the same tooth and in conjunction with fillings, prosthetic services, root canal therapy or repairs, inlays and crowns are not covered.

- Splints are covered only in connection with the replacement of a missing tooth. GHI will cover only that portion of the splint replacing the missing tooth. Splints using enamelite or similar material are not covered.
- Achatite synthetic fiber and unscheduled dressing changes are not covered.

GHI will also cover localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth. This must be performed in conjunction with periodontal scaling and root planning or periodontal maintenance. GHI will cover two (2) teeth per quadrant, eight (8) teeth per mouth in each twenty-four (24) month period.

**Major Restorative Services.** If major restorative services are included in a type of dental service that is listed as “covered” in the Attachment, then GHI will cover major restorative services. These services include: crowns; inlays; prosthetic services; removable, complete and partial dentures; fixed bridges; and crowns or inlays used as abutments. You may obtain a Predetermination of Benefits for certain Major Restorative Services. (See Article Five). The following guidelines apply to your coverage for Major Restorative Services.

- Replacement or the substitution of inlays and single crowns is covered only after [five (5) –ten (10)] years have passed since the appliance was inserted.
- Posts are covered only if there is evidence of root canal therapy on the tooth.
- Pins are covered once every six (6) months. However, pins are not covered if they are inserted in conjunction with a prosthetic service.
- Core buildups including pins are not covered.
- Acrylic crowns are only covered on the six (6) anterior teeth. They must be laboratory processed and permanent. The allowance for acrylic crowns will be the Schedule amount for single crowns, no the Scheduled amount for a bridge abutment or splint.
- If a three (3) surface inlay, crown or abutment is done on a tooth that has been filled within the last six (6) month period, GHI will deduct the Scheduled or Allowed amount for the filling from its payment for the inlay, crown or abutment.
- If an onlay and inlay are done on the same tooth on the same day, GHI’s allowance will be the Scheduled or Allowed amount for the inlay. A separate allowance for the onlay will not be provided.
- The allowance for composite resin inlays will be the Scheduled or Allowed amount for a filling.
- The charge for cementation for a crown/inlay is included in the allowance for the crown/inlay.
- GHI will cover splints only when a missing tooth is being replaced. Only that portion replacing the missing tooth is covered.
- Precious metal material used in crowns is reimbursed at base metal rate.
- There is no separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for the completed, permanent service or appliance.

The procedures listed below are excluded from Major Restorative Services coverage.

- Implants.
- Crowns used in splints for periodontal conditions.
- Crown build-ups done in connection with individual crowns and abutments.
- Services or appliances used solely as an adjunct to periodontal care.
- Tissue conditioning and stress breakers.
- Cosmetic surgery and/or treatment unless otherwise medically necessary.

**Fixed & Removable Prosthodontics.** If fixed and removable prosthodontics is included in a type of dental service that is listed as “covered” in the Attachment, then GHI will cover removable and fixed prosthodontic services as set forth below. You may obtain a Predetermination of Benefits for certain prosthetic services and appliances. (See Article Five). Note that there is no separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for the completed, permanent service or appliance.

- GHI will cover dentures that are constructed prior to the removal of teeth. These are known as immediate dentures. The dentures must be put in the same day the teeth are removed.
- GHI will cover permanent dentures. These may be full or partial.
- GHI will cover fixed bridgework and removable partial dentures.
- Implants and transplantations are not covered.
- Posts are covered only if there is evidence of root canal therapy on the tooth.
- Pins are covered once every six (6) months. However, pins are not covered if they are inserted in conjunction with a prosthetic service.
- Core buildups including pins are not covered.

Fixed & Removable Prosthodontics coverage is subject to the guidelines below.

- If the repair of a partial denture is done in conjunction with the insertion of a new denture in the same area of the mouth, GHI's allowance will be the Scheduled amount for the insertion of the new denture.
- If a denture adjustment is performed in conjunction with palliative treatment, GHI's allowance will be the Scheduled amount for the palliative treatment.
- The allowance for an upper or lower overdenture will be the Scheduled amount for full upper and lower dentures. There will be no benefits for any treatment of the abutment tooth or attachment tooth.
- Replacement or the substitution of appliances is covered only after [five (5) – ten (10)] years have passed since the appliance was inserted.
- When a fixed bridge and a partial denture are inserted in the same arch, only the partial denture is covered unless [five (5) – ten (10)] years have passed since the prior insertion of the fixed bridge or partial denture.
- You are covered for crowns or pontics for attachment or clasp purposes, only if the tooth is so broken down that it cannot be restored by fillings.
- You are covered for splints only when a missing tooth is being replaced. Only that portion replacing the missing tooth is covered.
- Crowns and inlays used as abutments are covered only when they are used as primary support for fixed appliances.
- Acrylic crowns are only covered on the six (6) anterior teeth. They must be laboratory processed and permanent. The allowance for Acrylic crowns will be the Scheduled amount for single crowns, not the Scheduled amount for a bridge abutment or splint.
- Adjustment of appliances are covered only after one (1) year of insertion.
- Precious metal material used in abutment crowns is reimbursed at base metal rate.
- There is not a separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for the completed, permanent service or appliance.

The procedures below are excluded from coverage under Fixed & Removable Prosthodontics.

- Implants.
- A cantilever pontic, when used for attachment purposes, is not covered.

- Double or multiple abutments.
- Crowns used in splints for periodontal conditions.
- Crown build-ups done in connection with abutment crowns.
- Services or appliances used solely as an adjunct to periodontal care.
- Precision attachment, metal coping, tissue conditioning and stress breakers.
- Cosmetic surgery and/or treatment unless otherwise medically necessary.

**Orthodontia.** If Orthodontia is included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover Orthodontia. Orthodontia is commonly known as the straightening of teeth. These services are covered only if rendered to covered unmarried, dependent children under the age set forth on the Attachment. GHI will not cover adult orthodontics unless the Attachment states that adult orthodontics is “covered.” If adult orthodontics is listed as “covered,” GHI will provide benefits for adult orthodontia to the same extent that orthodontia benefits would be available to a dependent child. You may obtain a Predetermination of Benefits for orthodontia. (See Article Five).

- GHI will issue payment for the first twenty (20) months of active comprehensive orthodontic treatment. This includes all office visits, appliances, follow-up visits and retention. There is no limit on the total number of months required for the completion of a full course of orthodontic treatment. The twenty (20) month benefit period represents reimbursement for the initial payment for the appliance fee and diagnostic work-up, up to the patient’s maximum. This provision does not apply if your benefit for the services is based upon the Preferred Plus Schedule of Allowances.
- The allowance for orthodontic treatment does not include charges for missed appointments or additional cosmetic banding options. Charges for these items are the responsibility of the member and reflect the dentists standard charges.
- GHI will not cover any appliance that was installed during a period when you were not covered under this Policy.
- GHI will not pay for the orthodontics unless it is medically necessary. The teeth must also be correctable.
- All orthodontic services will be deemed rendered on the date performed. The purpose of this is only important in determining work progress at the start or end of your coverage.
- If GHI covered a preliminary appliance, that payment will be deducted from the total payment for the insertion of a permanent appliance. If the appliance was inserted before you became covered under this Policy, GHI will not cover the appliance.
- There is no separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for the completed, permanent service or appliance.

#### **ARTICLE FOUR - EXTENT OF BENEFITS**

**1. Covered Services.** This Policy covers only the dental services included under a dental service type that is listed as “covered” on the Attachment and described in this Certificate. Coverage is subject to all terms, conditions, limitations and exclusions set forth in this Certificate, the Attachment and the Group Contract. You are responsible for a Provider’s normal charge for a service that is not a covered service under this Policy.

**2. Deductible.** You may be subject to a deductible(s). If so, the amount of the deductible(s) is set forth on the Attachment. Each calendar year, you must meet the deductible(s) before GHI will pay benefits for covered services. The

amount credited toward your deductible(s) is based upon the Schedule of Allowances or Allowed Charge. It is not based upon your out-of-pocket expenses or your Provider's charge.

**3. Coinsurance.** You may be required to share the cost of some or all covered services. This is known as coinsurance. Coinsurance is a percentage of the Scheduled or Allowed amount payable by you, not GHI, for covered services. For example, if the Attachment states that GHI will pay eighty percent (80%) of the Schedule of Allowances or Allowed Charge for a covered service, you must pay coinsurance in the amount of the remaining twenty percent (20%) of the Scheduled or Allowed amount for the service (in addition to any applicable deductible amount). There may be certain other charges that you are responsible to pay that are not considered to be coinsurance. For example, you are responsible to pay for:

- Annual deductible(s), if any.
- Charges for services and/or materials that are not covered.
- Charges that exceed the Schedule of Allowance or Allowed Charge for a covered service if Non-Network Providers are used.
- Charges incurred in a calendar year after you have exhausted the annual maximum.
- Charges incurred after you have exhausted the lifetime maximum.

**4. Annual Maximum.** GHI will only pay up to a certain dollar amount in benefits per person per calendar year under this Policy. This amount is known as the annual maximum. Your annual maximum(s) is shown on the attachment. GHI will not pay more than this amount per person in each calendar year.

**5. Lifetime Maximum.** GHI will only pay up to a certain dollar amount of benefits per person per lifetime for orthodontic services. This amount is known as the lifetime maximum. If Orthodontic Services are listed as "covered" on the Attachment, the amount of the orthodontic lifetime maximum benefit is also set forth on the Attachment. GHI will not pay more than this amount per person per lifetime for orthodontic services.

**6. Time of Charge.** GHI will consider a charge to be incurred on the date the service is rendered.

**7. Services Rendered by a Network Provider.** A Network Provider has agreed with GHI to accept GHI's Schedule(s) of Allowances or negotiated rate(s) as payment in full for covered services. If the Attachment indicates that GHI will provide benefits for services received from Network Providers and you use a Network Provider, GHI will pay the Network Provider directly for covered services, less any deductible and coinsurance that applies to your coverage.

A Network Provider will bill you for any deductible and coinsurance that applies to your coverage. A Network Provider will also bill you for services that are not covered and for services rendered to you after you have exhausted applicable annual and/or lifetime maximums.

**8. Services Rendered by Non-Network Provider.** A Non-Network Provider has not agreed with GHI to accept GHI's Schedule(s) of Allowances or negotiated rate(s) as payment in full for covered services or is not part of the Provider network that applies to this Policy.

If you use a Non-Network Provider, you must file a claim form with GHI. If the Attachment indicates that GHI will provide benefits for services received from Non-Network Providers, then GHI will reimburse you at the applicable Scheduled or Allowed amount for dental services listed as "covered" in the Attachment, less any deductible and coinsurance that applies to your coverage. You are responsible to pay any difference between GHI's payment and the Non-Network Provider's charge.

## ARTICLE FIVE - PREDETERMINATION OF BENEFITS

You may contact GHI to obtain a Predetermination of Benefits prior to the onset of certain treatments. Predetermination of Benefits is a process by which GHI reviews and estimates benefits before certain services are rendered.

To obtain a Predetermination of Benefits, you must submit a Treatment Plan to GHI before receiving any oral surgery, prosthetic services, appliances or orthodontic services. GHI will review the Treatment Plan and inform you and your Dentist or Provider of the results of this review. The results will provide an estimate of the benefit(s) that GHI will provide for the item or service. It will also state if any item or service is not covered and why it is not covered. This estimate may change based upon any new information received by GHI after it has issued the Predetermination of Benefits.

If you do not take advantage of the Predetermination of Benefits service, you will not know in advance the services and materials that GHI will cover or the benefits that GHI will provide. GHI reserves the right to determine your benefits taking into account alternate procedures, services or courses of treatment. If you or your provider feel that the alternate procedure, service or course of treatment is not appropriate in your case, your request will be subject to medical necessity review and internal and external utilization review appeals. (See Articles One and Seven).

Predetermination of Benefits is not available for the Preventive and Diagnostic Services.

IMPORTANT: Please note that Predetermination of Benefits is available only for certain types of dental services. Network Providers usually have a list of the American Dental Association (ADA) codes for which Predetermination of Benefits is available. Non-Network Providers may not have this list. Before receiving any oral surgery or prosthetic or orthodontic services, you should obtain the ADA procedure code(s) for the service(s) you will receive and call GHI to determine whether Predetermination of Benefits is available for the service(s). If so, you should ask your Provider to submit a Treatment Plan to GHI before services are rendered if you would like a Predetermination of Benefits.

## ARTICLE SIX – GENERAL LIMITATIONS AND EXCLUSIONS

This dental policy does not cover all dental services. In addition to the exclusions and limitations noted elsewhere in this Certificate and the Attachment, benefits are not available for the services set forth below.

- **Cosmetic Surgery or Treatment.** You are not covered for cosmetic surgery or for cosmetic treatment unless otherwise medically necessary. Cosmetic surgery is covered only when the cosmetic surgery or treatment involves reconstructive surgery incidental to or following surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery arising out of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
- **Care Furnished Without Charge.** You are not covered for services for which no charge is incurred.
- **Treatment Not Conforming to Accepted Dental Standards.** You are not covered for services that do not conform to accepted standards of dental practice. You are also not covered for services that are considered experimental in terms of generally accepted dental standards, unless recommended by an external appeal agent.
- **Services Not Listed as Covered.** You are covered only for those dental services that are described in this Certificate and included within a dental service type that is listed as “covered” in the Attachment. Other dental services are not covered, even if the dental services are described in this Certificate. However, GHI, in its sole discretion, may cover unlisted dental procedures that are of the types covered under your Policy. In such cases, GHI will determine payment in a manner consistent with the Schedule.
- **Services Covered by Government.** You are not covered for services to the extent that your service is covered under any law of any State or the United States. An example of this would be when your service is covered by Medicare or Workers’ Compensation. Services provided under Medicaid do not apply.

- **Services Through Your Employer or Welfare Fund.** You are not covered for services rendered in a hospital, department or clinic run by your employer, labor union or welfare fund.
- **No Fault Automobile Insurance.** You are not covered for any service for which automobile no fault insurance benefits are recovered or recoverable.
- **Services Rendered by Member of Immediate Family.** You are not covered for services rendered by the Subscriber, the Subscriber's spouse, or a child, brother, sister or parent of the Subscriber or of the Subscriber's spouse.
- **Workers' Compensation.** You are not covered for care for any injury, condition or disease if payment is available to you under a Workers' Compensation Law or similar legislation. GHI will not make payment even if you do not claim benefits you are entitled to receive under the Workers' Compensation Law. Payment will not be made even if you bring a lawsuit against the person who caused the injury or condition. Payment will not be made even if you receive money from that lawsuit and you have repaid the provider of services.
- **Prohibited Referrals.** You are not covered for clinical laboratory services, x-ray or imaging services or other services provided pursuant to a referral prohibited by Section 238-a(1) of the New York State Public Health Law. This law prohibits your dentist or physician from making referrals for such services to providers in which your dentist or physician, or a member of their immediate family, has a financial interest.
- **Items and Services to Comply with Federal, State or Local Laws.** Charges for items and services used or provided by Dentists and Providers to comply with federal, state and local laws and regulations are not covered unless specifically listed as covered in this Policy.
- **Prescription Drugs and Medications.** Prescription drugs and medications are not covered.
- **Substitution of Material and Services.** When a more costly material or service is substituted for a less costly material or service having the same function, the allowance for the less costly material or service will be applied.
- **Injuries Due to War or an Act of War.** Services rendered for any injury or condition due to war or any act of war, whether declared or undeclared, are not covered.
- **TMJ Disorders.** Services and appliances for the treatment of temporo-mandibular joint (TMJ) dysfunction syndrome are not covered.
- **Behavioral Management.** Costs incurred for behavioral management are not covered.
- **Teeth Lost or Missing Before You Became Covered Under this Policy.** You may have one or more congenitally missing teeth or have lost one or more teeth before you became covered by this Policy. GHI will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after you became insured by this Policy.
- **Benefit Waiting Period.** This Policy may impose a waiting period(s) for certain dental services when your Group first becomes covered under this Policy. If such a waiting period(s) applies, this Policy will not cover the dental services that are subject to the waiting period(s) until the Group Contract has been in effect for the length of the waiting period(s). The Attachment will tell you whether or not such a waiting period(s) applies. The Attachment will also tell you the length of the waiting period(s) and it will set forth the dental services that are subject to the waiting period(s). For example, if the Attachment indicates that a twelve (12) month waiting period applies to orthodontia under this Policy, then this Policy does not cover orthodontia services performed during the first twelve (12) months the Group Contract was in effect. Note that the effective date of the Group Contract may pre-date your individual effective date of coverage under this Policy. GHI will never pay for any services performed prior to your individual effective date of coverage under this Policy.

- **Late Entrant Waiting Period.** Late entrants may be subject to a waiting period for certain dental benefits. A late entrant is any person whose effective date of coverage under this Policy is more than thirty (31) days from the date the person qualifies for the coverage, or who has elected to become insured again after canceling a premium contribution agreement. The Attachment will tell you whether or not a waiting period applies to late entrants. If a waiting period applies, the Attachment will also set forth the length of the waiting period and the dental services that are subject to the waiting period. A late entrant is not eligible for those dental service(s) that are subject to the waiting period until he/she has been covered under this Policy for the length of the waiting period. For example, if the Attachment indicates that late entrants are subject to a twelve (12) month waiting period for orthodontia, then a late entrant is not covered for orthodontia performed during the first twelve (12) months that he/she is covered under this Policy.

## ARTICLE SEVEN - FILING OF CLAIMS, GRIEVANCES AND APPEALS

**1. Filing of Claims.** In order to receive benefits, you must promptly complete and file a GHI dental claim form. You should file your claim form with GHI within thirty (30) days after the services are completed. You must file your claim form with GHI within eighteen (18) months of the date upon which a service has been rendered. If you fail to file your claim on time, GHI may still pay the claim if GHI determines that it was not reasonably possible for you to have filed your claim on time and that your claim was filed as soon as it became reasonably possible to do so. After GHI receives your claim form, GHI may ask for more information in support of the claim. You must give GHI the information it needs to process your claim. Claim forms should be sent to GHI at:

[GHI Dental Claims  
P.O. Box 2838  
New York, New York 10016-2838]

**2. Grievances and Internal Appeals.** If you do not agree with GHI's disposition of a claim or any other determination made by GHI, you or your designated representative may ask GHI to reconsider its determination. If GHI determines that a service is not medically necessary or is experimental or investigational in nature without first speaking with your Provider, the Provider also has the right to ask GHI to reconsider its decision.

- (a) **Grievances.** If you do not agree with a determination made by GHI other than a denial or reduction of coverage on the basis that services are not medically necessary or are experimental or investigational, you or your designated representative may file a grievance with the GHI Subscriber Relations Department asking GHI to reconsider its decision. Your grievance should include your GHI identification number, claim number(s) and any other information that you wish GHI to review. GHI will notify you of its decision within sixty (60) days after GHI's receipt of your grievance. Please send your written grievance to: [GHI – Dental Correspondence, P.O. Box 1701, New York, New York 10023-9476 or call 1-888-906-7668.]
- (b) **Your Provider's Right to Reconsideration.** If GHI decides that a service is not medically necessary or is experimental or investigational in nature without first discussing it with your Provider, your Provider may request a reconsideration by GHI. If you have not yet received the service, GHI will reconsider within one (1) business day of GHI's receipt of the request. If the service has already been provided to you, GHI will reconsider within thirty (30) days.
- (c) **Internal Appeals.** If GHI has denied your claim for covered services on the basis that the services are not medically necessary or they are experimental or investigational in nature, you or your designated representative may file an appeal with GHI. The appeal may be filed either by telephone or in writing. It must be filed within one hundred and eighty (180) days from the date you receive notice of GHI's decision. When filing an appeal, please include

your GHI identification number. Also include the claim number(s) as well as any medical data and comments in support of your appeal.

GHI will acknowledge receipt of your appeal in writing within fifteen (15) days of its receipt. A clinical peer reviewer other than the clinical peer reviewer who made GHI's initial decision will review the appeal. GHI will make a decision on your appeal within sixty (60) days of receipt of the appeal and any information needed for GHI to conduct a full and fair review. GHI will notify you of the reason for GHI's decision. If GHI upholds its denial on the appeal, then the notice will include the clinical reasons for the decision. The notice will also include notice of your right to file an external appeal along with an external appeal application. It will also include notice of other rights available to you. If GHI fails to make a decision on your appeal within the timeframe above, the decision will be deemed to be a reversal of GHI's denial.

To file a verbal appeal, please call toll free: [1 (888) 906-7668]

To file a written appeal, please write to:

[GHI Dental, Professional Review  
P.O. Box 2838  
New York, New York 10016-2838]

- (d) **Expedited Internal Appeals.** GHI offers an expedited appeal process in certain cases. Expedited appeals may be taken in cases that involve continued or extended dental services, procedures or treatments; requests for additional services for a person undergoing a course of continued treatment; and cases in which the Dentist or Provider believes an immediate appeal is warranted, except any retrospective determination. GHI will provide reasonable access to its clinical peer reviewer within one (1) business day of GHI's receipt of notice of the filing of an expedited appeal. GHI will render a decision within two (2) business days of GHI's receipt of the expedited appeal and any information needed for GHI to conduct a full and fair review, but not more than seventy-two (72) hours from GHI's receipt of the appeal. To file an expedited appeal, please call GHI toll free at: [1 (888)906-7668].

### 3. External Appeals.

**Your Right to an External Appeal.** Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if GHI has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the State of New York to conduct such appeals.

**Your Right to Appeal a Determination That a Service is Not Medically Necessary.** If GHI has denied coverage on the basis that the service is not medically necessary, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

- The service, procedure or treatment must otherwise be a covered service under this Policy; and
- You must have received a final adverse determination through GHI's internal appeal process and GHI must have upheld the denial or you and GHI must agree in writing to waive any internal appeal.

**Your Right to Appeal a Determination That a Service is Experimental or Investigational.** If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

- The service must otherwise be a covered service under this Policy; and
- You must have received a final adverse determination through GHI's internal appeal process and GHI must have upheld the denial or you and GHI must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life threatening or disabling condition or disease. A “life-threatening condition or disease” is one that, according to the current diagnosis of your attending physician, has a high probability of death. A “disabling condition or disease” is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a “disabling condition or disease” is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by GHI or one for which there exists a clinical trial (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable): or
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

**The External Appeal Process.** If, through GHI’s internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have forty-five (45) days from receipt of such notice to file a written request for an external appeal. If you and GHI have agreed in writing to waive any internal appeal, you have forty-five (45) days from receipt of such waiver to file a written request for an external appeal. GHI will provide an external appeal application with the final adverse determination issued through the GHI’s internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from New York State at (800) 400-8882. Submit the completed application to State Department of Insurance at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which GHI based its denial, the external appeal agent will share this information with GHI in order for it to exercise its right to reconsider its decision. If GHI chooses to exercise this right, GHI will have three (3) business days to amend or confirm its decision. Please note that in the case of an external expedited appeal (described below), GHI does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within thirty (30) days of receipt of your completed application. The external appeal agent may request additional information from you, your physician or GHI. If the external appeal agent requested additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within three (3) days of receipt of your completed application. Immediately after reaching a

decision, the external appeal agent must try to notify you and GHI by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns GHI's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, GHI will provide coverage subject to the other terms and conditions of this Policy. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, GHI will only cover the costs of services required to provide treatment to you according to the design of the trial. GHI shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Policy for non-experimental or non-investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and GHI. The external appeal agent's decision is admissible in any court proceeding.

GHI will charge you a fee of \$50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. GHI will also waive the fee if GHI determines that paying the fee would pose a hardship to you. If the external appeal agent overturns the denial of coverage, the fee shall be refunded to you.

**Your Responsibilities.** It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

Under New York State law, your completed request for appeal must be filed within forty-five (45) days of either the date upon which you receive written notification from GHI that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. GHI has no authority to grant an extension of this deadline.

## **ARTICLE EIGHT - COORDINATION OF BENEFITS**

You may be covered by two or more group health insurance plans. These plans may provide similar benefits. If you have services covered by more than one plan, GHI will coordinate benefit payments with the other plan. In this case, one plan pays its full benefit as a primary benefit. The other plan pays secondary benefits. This prevents duplicate payments and overpayments. In no event will payments exceed one hundred percent (100%) of a charge. If GHI is both the primary and secondary plan, GHI will pay only up to the higher of the two (2) allowances, less any applicable GHI deductibles, coinsurance and/or Co-pay Charge(s) that apply to the secondary plan.

In order to determine which plan is primary, certain rules have been set. GHI will follow these rules. These rules apply whether or not you make a claim under both plans.

If GHI pays you more than you should have been paid under this provision, it has the right to recover the overpayment. GHI may recover the overpayment from you or any other person, insurance company, or other organization that gained from the overpayment. You must help GHI in recovering any overpayment. This may mean filing claim forms with another company. It may mean endorsing checks over to GHI.

GHI has the right to decide which facts it needs in order to coordinate benefits. GHI may get needed facts from or give needed facts to any organization or person. GHI need not tell or obtain the consent of any person to do this, except as required by the New York State Fair Credit Reporting Act. You must give GHI any facts it needs to process a claim and coordinate benefits.

**1. Plan.** A plan is a form of group coverage other than Medicaid for which these rules of coordination of benefits are allowed.

A plan may include:

- (a) Group insurance, group or group remittance subscriber contracts.
- (b) Self-Insured group coverage.
- (c) Prepayment group coverage, including HMOs, group practice and individual practice plans.
- (d) Blanket contracts, except blanket school accident coverage or such coverage issued to a substantially similar group, where the policyholder pays the premium.
- (e) The medical benefits coverage in group and individual mandatory automobile no-fault contracts.

**2. Rules of Coordination.** The rules for determining primary and secondary benefits are set forth below.

- (a) The plan covering you as an employee is primary before a plan covering you as a dependent.
- (b) The plan of a parent whose birthday occurs first in the year is primary for dependent children covered under plans maintained by both parents. Birthday refers only to the month and day on which the parent is born and not the year. If both parents have the same birthday, the plan covering you the longer time is primary. If the other plan does not have the rule set forth above, but has a rule based upon the gender of the parent, that plan's rule will determine the order of benefits.
- (c) If no other criteria apply, the plan covering you the longest is primary. However, the plan covering you as a laid-off or retired employee, or as a dependent of such a person, shall be secondary and the plan covering you as an active employee or a dependent of an active employee shall be primary as long as the other plan has a COB provision similar to this one.

**3. Special Rules for Dependents of Separated or Divorced Parents.**

- (a) If there is a court decree that imposes financial responsibility for the health care expenses of the dependent child on one parent, that parent's plan is primary. That plan must have actual knowledge of the decree. GHI has the right to request a copy of the portion of the decree pertaining to the health care expenses of the dependent child.
- (b) If there is no court decree, the plan covering the parent with custody of a dependent child is primary.
- (c) If the parent with custody of a dependent child remarries, that parent's plan is primary. The stepparent's plan is secondary. The plan covering the parent without custody is tertiary.

**4. Payment of Benefits.**

- (a) When GHI is the primary plan, GHI will pay its full benefits. The other plan will pay secondary benefits.
- (b) When GHI is deemed secondary, GHI will reduce its benefits so that the combined payment or benefit from all plans is not more than the actual charge for the covered service. Please note that GHI will never pay more than its full benefits as a secondary plan, even if the benefits or payments of the combined plans are less than one hundred percent (100%) of charges.

**5. Plans with Different COB Rules.** Group plans are written in many states. Not all states or groups follow the same rules. Some plans have language that states that the plan is an "excess" plan or is "always secondary". In that event, GHI will coordinate as set forth below.

- (a) If GHI would be primary under the rules listed above, it will pay primary benefits.
- (b) If GHI would be secondary under the rules listed above, it will pay its benefits first. However, the amount of benefits paid will be determined as if GHI was the secondary plan. Such payment will be the limit of GHI's liability

- (c) In order to determine benefits under (b), GHI may need information from the other plan. If that plan does not provide the information necessary for GHI to determine benefits within thirty (30) days of a request to do so, GHI will assume the benefits of the other plan are identical to GHI's. Benefits will then be paid accordingly. Adjustments will be made if information becomes available as to the benefits of the other plan.

## **ARTICLE NINE - TERMINATION**

**1. Termination.** Your coverage under this Policy will terminate in the event of any of the circumstances set forth below.

(a) You are no longer eligible for group benefits. Examples of loss of eligibility may include:

- the Subscriber's loss of employment with or membership in the group;
- divorce from the Subscriber;
- death of the Subscriber;
- a dependent reaching the age limitation.

(b) The Group Contract between your Group and GHI is terminated.

(c) By operation of law. You will be notified as required by law.

**2. Benefits after Termination.** If your coverage is terminated through no fault of your own, GHI will provide a sixty (60) day extension of benefits for covered dental procedures/treatment in progress on the date of termination of coverage. A dental procedure or treatment is in progress if it was commenced prior to the termination of your coverage and its completion requires a number of visits pursuant to a defined treatment plan. Treatment provided after your coverage has terminated for a condition treated while your coverage was in effect is not treatment in progress unless it is part of a defined treatment plan and the treatment commenced prior to the termination of your coverage. Benefits will not be extended for dental procedures and treatments that require only one visit for completion.

## **ARTICLE TEN - MISCELLANEOUS PROVISIONS**

**1. No Assignment.** You cannot, without GHI's consent, assign any benefits, payments, causes of action or rights to appeal benefits or claims determinations under this policy to any person, corporation, or other organization. Any assignment by you will be void. Assignment means the transfer to another person or organization of your right to the services provided or your rights under this policy.

**2. Your Dental Records.** In order to process your claims it may be necessary for GHI to obtain records and data from practitioners who treated you. When you become covered, you give GHI permission to obtain and use these records. The information will be kept confidential.

**3. Recovery of Overpayments.** If GHI pays benefits under this policy for services incurred on your account and it is found that GHI paid more benefits than should have been paid because you were: (a) not covered; (b) the services were not covered; (c) payment was in an amount greater than that to which you are entitled under this policy; or (d) payment was in an amount greater than that to which you are entitled because you were repaid for all or some of those expenses by another source; then GHI will have the right to a refund from you. You must return the amount of the overpayment within sixty (60) days of GHI's request. In addition, if you (or your legal representative, estate or heirs) make recovery from any liable party (including an insurance carrier) and the funds that are specifically identified in the judgement or settlement as medical expenses that GHI has previously paid, you must promptly reimburse GHI for any proceeds received.

**4. Lawsuits.** A lawsuit against GHI regarding this policy must be started within two (2) years from the date you received the service for which you want GHI to pay.

**5. New York Law.** This policy is in all respects governed by the laws of New York State.

**6. Who Receives Payment Under This Policy.** Payments for covered services rendered by a Network Provider will be made directly to that Network Provider. If you receive covered services from a Non-Network Provider, GHI reserves the right to pay you or the Provider.

**7. Patient's Relationship with the Dentist or Provider.** Nothing in this Policy shall force a Dentist or Provider to accept you as a patient. This Policy is not meant to change the normal relationship between the provider and patient. At all times, the provider's usual rules will govern the service provided to the patient. GHI cannot guarantee receipt of any particular service or accommodation.

**8. Non-Vesting.** Under no circumstances do you acquire a vested interest in continued receipt of a particular benefit or level of benefits. Benefits shall be determined according to the Group Contract terms in effect when an expense is incurred. Benefits may be amended at any time in accordance with applicable provisions of the Group Contract.

