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Exhibit A

GHI Preferred Program's fee schedule for out-of-network providers



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This dental plan provides benefits for most types of dental services. Your level of dental benefits is known as the GHI Preferred Dental Plan. This document is your Certificate of Insurance.

Dental Insurance Benefits and Deductible

This dental insurance plan provides coverage for you and your family. Like most dental plans, it will not pay all the bills you may incur for dental care for yourself or your dependents.

Dental Insurance Coverage

You are subject to a calendar year deductible for all services except Preventive and Diagnostic Services and Orthodontics. The deductible is \$25 per person per year. The total family deductible will not exceed \$75 per year for all covered family members. The amount credited towards the deductible is based on GHI's Schedule of Allowances, not the amount charged by the dentist or physician. Dental services rendered by participating and non-participating providers are covered to the extent that they are a covered service, are necessary for dental health and are performed by a licensed dentist or physician.

When covered services are rendered by non-participating providers, you are reimbursed based on the Reimbursement Schedule. When rendered by participating providers, these dental services are covered on a paid-in-full basis.

GHI may cover unlisted dental procedures that are of the type listed in the Reimbursement Schedule. GHI will cover such procedures at its sole discretion. GHI will determine payment in a manner consistent with the Reimbursement Schedule.

Selecting a Dentist—Freedom Of Choice

Enrollees are free to go to any licensed dentist for covered services. This includes participating and non-participating dentists. When you use a participating dentist, however, your out-of-pocket costs, if any, are minimal, and a higher level of benefits is provided. The freedom to make that choice is always yours.

Your GHI Dental Insurance I.D. Card

Your GHI Dental Insurance I.D. Card indicates your Certificate and Category numbers. You should show this card to the dentist or receptionist before services are performed.

Participating Dentists And Participating Specialists

If you use a Participating Dentist:

Many dentists have agreed to be participating dentists in GHI's Preferred Dental Plan. A participating dentist is either a dentist in General Practice or a Specialist who has agreed to accept GHI's Preferred Dental Schedule of Allowances as payment-in-full for covered services, up to the annual maximum of \$1,800. (Note: Specific services which are not covered are shown under Dental Exclusions. Those services that have limitations are noted as such in the Covered Services and Limitations section of this certificate.)

You must advise the dentist of your GHI coverage and confirm that he or she is currently a participating dentist in the GHI Preferred Dental Plan before services are rendered. GHI reimburses participating dentists/specialists directly for covered services which means you do not have to submit any claim forms. For information regarding the GHI Preferred Dental Plan and to obtain the names of participating dentists in your area, refer to the Directory of Participating Dentists, call GHI Customer Service at 1-800-947-0101.

Non-Participating Dentists

If you use a non-participating dentist:

A non-participating dentist has no agreement with GHI to limit fees. You must pay the non-participating dentist directly and then file a dental claim form with GHI. GHI will then reimburse you for covered services based on the Reimbursement Schedule. This Schedule shows GHI's maximum reimbursement to you for covered services. You are responsible for any difference between the GHI payment for services rendered by the non-participating dentist and the non-participating dentist's charge. (Note: Specific services which are not covered are shown under Dental Exclusions. Those services that have limitations are noted as such in the Covered Services and Limitations section of this certificate.)

Covered Services and Limitations

Preventive and diagnostic services

Examinations: You are covered for the routine examination of the oral cavity and the charting of teeth. GHI will cover two (2) examinations for each Member per calendar year. You are eligible for one (1) initial examination per provider per lifetime. All subsequent non-emergency examinations done by the same provider are paid as periodic examinations.

Prophylaxes: You are covered for Prophylaxis which is the scaling, cleaning and polishing of teeth. You are covered for two (2) prophylaxes per calendar year. Prophylaxis is not payable if periodontic treatment is rendered on the same day.

X-Rays: You are covered for the taking of x-ray films of the teeth, mouth or jaw. You are covered for four (4) bitewing x-rays in each calendar year. GHI will cover fourteen (14) standard periapical x-ray films or one (1) panoramic film once every three (3) 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.

Fluoride treatment: Each covered dependent child is eligible for one fluoride treatment per calendar year.

Sealants: Each covered dependent child is eligible for sealants to the end of the month in which the child reaches age 14. Sealants are covered only when applied to the occlusal (biting) surface of the first and second permanent molars and bicuspid if these teeth have not previously been filled. Coverage is provided once per covered tooth every three (3) years.

Space maintainers: Each covered dependent child is eligible for space maintainers. Coverage includes the treatment and the appliance. If the insertion of a space maintainer is performed in conjunction with the recementation of a space maintainer, GHI will only pay for insertion of the space maintainer. A separate allowance will not be provided for the recementation.

Tests and lab examinations: You are covered for biopsy and examination of oral tissue. However, you are not covered for sialography, TMJ arthrogram including injection, tomographic survey, bacteriological studies, caries susceptibility, pulp vitality test, diagnostic casts and photographs, nutritional counseling or oral hygiene instructions.

Palliative services: You are covered for one **emergency** palliative visit per year. A palliative visit is for the relief of pain. This includes an adjustment of a prosthetic appliance which must have been inserted for over one (1) year.

Mouth guards: Each dependent child is covered for one (1) mouth guard per lifetime. It must be prescribed by a dentist and used for athletic purposes.

Basic Restorative Services

Extractions: You are covered for the routine removal of a tooth or teeth. The allowance for the extraction includes payment for pre- and post-operative x-rays, post operative care and local anesthesia.

Restorations: You are covered for restorations which are fillings, inlays and crowns. This amount applies even if you have a crown or an inlay. Temporary fillings, acid etch, sedative fillings or tissue conditioning are not covered.

Amalgam restorations are denied when reported with a fixed prosthetic or crown procedure on the same tooth.

- There is 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 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 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 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 Amount for a one (1) surface amalgam.
- The allowance for an onlay will be the Scheduled Amount for a three (3) surface inlay. If an onlay and three (3) surface inlay are done on the same tooth on the same day, GHI's allowance will be the Scheduled Amount for the three (3) surface inlay. A separate allowance for the onlay will not be provided.
- The allowance for composite resin inlays will be the Scheduled Amount for amalgam restorations.
- The charge for cementation of a crown/inlay is included in the allowance for the crown/inlay.
- 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.
- The allowance for chairside laminates for anterior teeth will be the comparable maximum composite Scheduled Amount.

Repair of appliances: You are covered for the repair of dentures, the replacement of broken or missing teeth or clasps in a denture and the replacement of broken facings. You are also covered for the repair of appliances including recementation of space maintainers, bridges, inlays and crowns. There is an annual maximum benefit for all repairs. GHI will not pay more than that maximum benefit for each member per calendar year.

Consultations: You are covered for consultation with a specialist in the field of oral surgery, orthodontics, periodontics or endodontics. The consultation is covered only if there is no other service rendered by the specialist on that date or during the next three (3) months. If treatment is performed by the consulting dentist within 90 days of the consultation, the consultation allowance will be reduced and processed as an exam. If you are referred by a dentist who practices in the same office or in association with the specialist, the consultation is not covered. The report of the specialist must be submitted with the claim form.

Endodontics: You are covered for endodontics commonly known as root canal therapy. This is treatment for the removal of pulp and the filling of the canals of the teeth that have damaged pulp.

- 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.
- If any combination of apicoectomy, root end amalgam and apical curettage is done on the same tooth by the same Dentist or Provider within a three (3) month period of root canal therapy, GHI will not apply the Scheduled Amounts for these services. GHI will apply a combined allowance for these services.
- 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.
- 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 Dentist or Provider will be deducted from the allowance for the root canal therapy or periodontal surgery.
- Pulp capping is not covered.
- Surgical replacement of rubber dam, recalcification of perforation, preparation of canal for post or dowels, and bleaching of discolored teeth are not covered.

Periodontics: You are covered for periodontics which is the treatment of diseases of the gums and the long structure of the jaw, including subgingival scaling, medication, curettage and minor bite correction (occlusal adjustment). You are covered for five (5) periodontal treatments per 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.
- 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 not covered except when a missing tooth is being replaced. Only the portion replacing the missing tooth is covered. Splints using enamelite or similar material are not covered.
- Achatite synthetic fiber and unscheduled dressing changes are not covered.
- Periodontal prophylaxis are counted toward the five treatments.

Oral surgery: You are covered for the removal of a tooth. You are covered for other surgical procedures in or about the oral cavity.

- X-rays taken solely for the surgery, local anesthesia and post operative care are not covered separately. They are included in the fee for oral surgery.
- There is 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.
- An alveolectomy done in conjunction with a surgical extraction is not covered.
- Surgery on fractured jaws, impactions, lesions in and around the mouth are covered. Orthognathic surgery, and surgery relating to accidental injury are not covered.
- Implants and transplantations are not covered. Reimplantations are covered. (Reimplantations are the return of a tooth to the bone to which a tooth is attached.)

Bedside calls: You are covered for bedside calls made during an emergency.

Anesthesia: You are covered for general anesthesia under the following conditions: The anesthesia must be rendered in connection with a covered service. It must be given by a practitioner licensed in New York State to administer anesthesia. The anesthesia may be rendered in or out of a hospital. Local anesthesia is included in the allowance for the procedure being performed.

Intravenous sedation: You are covered for intravenous sedation when rendered in connection with a covered service and administered according to American Dental Association guidelines. You are not covered for nitrous oxide.

Temporary services and appliances: 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.

Major Restorative Services

(These services are subject to a five year frequency limitation.)

You are covered for:

- Dentures which are constructed prior to the removal of teeth and inserted on the same day the teeth are removed. These are known as immediate dentures.
- Full or partial permanent dentures.
- Fixed bridgework and removable partial dentures.
- Crowns and inlays inserted on teeth. They are covered only if a tooth cannot be restored by filling. If it can be restored, the Scheduled Amount for a filling will be paid.
- Crowns over implants.

There are specific limits on your coverage for Major Restorative services. These limits are set forth 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.
- If the repair of a broken denture is performed in the same arch as the insertion of a full denture, GHI's allowance will be the Scheduled Amount for the insertion of the new denture.
- 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.
- You are not covered for the replacement or the substitution of appliances unless five (5) years have passed since the appliance was inserted.
- If a fixed bridge and partial denture are inserted in the same arch, only the partial denture is covered during the prosthetic replacement limitation period of five (5) years.
- You are not covered for implants.
- You are not covered for double or multiple abutments.
- Crowns or pontics for attachment or clasp purposes are not covered unless the tooth is so broken down that it cannot be restored by fillings. A cantilever pontic used for attachment purposes is not covered.
- Splints are not covered except when a missing tooth is being replaced. Only the portion replacing the missing tooth is covered.
- Crowns used in splints for periodontal conditions are not covered.
- Crown buildups done in connection with individual crowns and abutments are not covered.
- Crowns and inlays used as abutments are not covered unless they are used as primary support for fixed appliances.
- Precious metal material used in crowns is reimbursed at a base metal rate.
- The allowance for a ceramic inlay/onlay is the maximum Scheduled Amount for an amalgam filling.
- Duplication, rebase or chairside relines to a denture is limited to one (1) per denture in a five year period. This applies to both full and partial dentures.
- 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.
- Rebase or repair of new dentures are not covered until six (6) months after insertion.
- Adjustment of appliances is not covered within one (1) year of insertion.
- GHI does not cover services or appliances used solely as an adjunct to periodontal care.
- Precision attachment, metal coping, tissue conditioning and stress breakers are not covered.
- Cosmetic surgery and/or treatment is not covered unless medically necessary.
- 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.

Orthodontic Services

The following limitations apply to coverage for Orthodontic treatment:

- Orthodontic Services are available only to your enrolled dependent children under 19 years of age. There is no coverage for completing a course of treatment for orthodontic service after age 18.
- GHI will not pay Orthodontic benefits unless the teeth are seriously abnormal. The teeth must also be correctable.
- It is recommended that you have your dentist request a pre-determination of benefits from GHI before Orthodontic treatment is started.
- MultiPhasal Orthodontia services are included in your benefit under the administration of insertion of appliances. Benefits for multi-phasal orthodontia and insertion of appliances will be provided up to a lifetime maximum of \$550.
- Each eligible enrollee is covered up to twenty (20) months of active treatment plus eighteen (18) months of passive treatment.
- The maximum lifetime orthodontic benefit per covered dependent is \$1,998.
- X-rays reported with an orthodontic appliance will be included in the appliance fee.
- Orthodontics to correct temporomandibular joint problems are not covered.
- Occlusal guards are not covered.
- 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.

Annual Maximum Amount

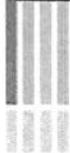
GHI will pay a maximum of \$2,000 in benefits including orthodontia (for dependent children under age 19), per person, per calendar year for covered dental services rendered by participating and non-participating providers.

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Dental Exclusions

Payment will not be made for:

- **Treatment Not Conforming to Accepted Dental Standards.** You are not covered for services that do not conform with accepted standards of dental practice. You are also not covered for services which are considered experimental in terms of generally accepted dental standards.
- **Care Furnished Without Charge.** You are not covered for services for which no charge is incurred.
- **Cosmetic Surgery or Treatment.** You are not covered for cosmetic surgery, or cosmetic treatment unless it is 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.
- **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 Workers' Compensation. Services provided under Medicaid do not apply, and GHI coverage would remain primary.
- **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.

- **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 paid.
 - **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.
 - **Services Not Listed as Covered.** GHI, in its sole discretion, may cover unlisted dental procedures that are of the type listed in the Reimbursement Schedule. In such cases, GHI will determine payment in a manner consistent with the Reimbursement Schedule.
 - **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 Certificate.
 - **Services Rendered by Member of Immediate Family.** You are not covered for services rendered by the Enrollee, the Enrollee's spouse, domestic partner or a child, brother, sister or parent of the Enrollee or of the Enrollee's spouse or domestic partner.
 - **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.
 - **TMJ Disorders.** Services and appliances for the treatment of temporomandibular joint (TMJ) dysfunction syndrome are not covered.
 - **Behavioral Management.** Costs incurred for behavioral management are not covered. These costs would include services necessary to treat the deeply dental phobic.
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Reimbursement Schedule

Preferred Dental Plan Non-Participating Provider Reimbursement Schedule as of January 1, 2009

The following is a selective listing of GHI's maximum reimbursements for common dental procedures rendered by non-participating dentists. As GHI's participating dentists accept GHI's payment as payment-in-full for covered services rendered, your personal out-of-pocket expenses, if any, are minimal and your benefits are maximized. All covered services rendered by participating and non-participating dentists are paid based on GHI's Preferred Dental Schedule of Allowances.

If the service is covered, the GHI allowance for that specific service is shown at 100% of the Preferred Dental Plan fee schedule. (Note: Under your current coverage Limited and Full Basic Services and Prosthetic Services rendered by a non-participating provider are reimbursed at 80% of the GHI Preferred Dental Allowance.)

The listing of the **most common dental procedures** shown below indicate the amount that GHI will reimburse for covered services rendered by non-participating providers. Your per person calendar year benefit maximum for covered participating and non-participating services is \$2,000 including orthodontia. Orthodontic services obtained during a calendar year are subject to both the calendar year maximum and the lifetime orthodontia maximum of \$1,998. Services that are not covered are listed under [Dental Exclusions](#). Those services that have limitations are noted as such in the [Covered Services and Limitations](#) section of this certificate.

Examinations

Procedure	Description	Maximum Reimbursement
00150	Comprehensive oral evaluation	\$22.00
00120	Periodic examination	\$19.00
00140	Limited oral evaluation, problem focused	\$19.00

Prophylaxes

Procedure	Description	Maximum Reimbursement
01120	Children under 12 years of age	\$26.00
01110	Adult	\$37.00

Fluoride Treatments

Procedure	Description	Maximum Reimbursement
01203	Topical application of fluoride, excluding prophylaxis, children	\$16.00

Sealants

Procedure	Description	Maximum Reimbursement
01351	Sealant per tooth	\$22.00

Covered to the end of month, age 14, on the first and second permanent molars and bicuspids once every three years.

Palliative Services

Procedure	Description	Maximum Reimbursement
09110	Emergency visit for relief of pain.	\$23.00

In certain circumstances, when a palliative treatment and another procedure are performed during the same visit, the allowance for the palliative treatment will be included in the allowance of the other procedure.

Radiology

Procedure	Description	Maximum Reimbursement

00220	Intra-oral periapical (standard x-ray films): Initial periapical x-ray	\$6.00
00230	Each additional film	\$5.00
00210	Maximum: one series each three years	\$51.00
00270	Initial Bitewing	\$6.00
00272	Bitewings-two films	\$14.00
00274	Bitewings-four films	\$28.00
00330	Panoramic (panoraphy)	\$35.00

GHI will cover fourteen (14) standard periapical x-ray films or one (1) panoramic film once every three (3) years. GHI will also cover two (2) occlusal intra-oral x-ray films in 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.

Space Maintainers and Mouth Guards

Procedure	Description	Maximum Reimbursement
01520	Space maintainer, removable, acrylic	\$120.00
01510	Fixed, unilateral band type	\$120.00
01515	Fixed, lingual or palatal arch band type	\$150.00
01525	Space maintainer, removal, bilateral	\$150.00
01550	Recementation space maintainer (dependents to age 19)	\$40.00
09941	An athletic mouth guard	\$70.00

Each dependent is covered for one mouth guard per lifetime. It must be prescribed by a dentist and used for athletic purposes.

Restorations (Fillings)

Procedure	Description	Maximum Reimbursement
02140	Amalgam — One surface, permanent	\$38.00
02150	Amalgam — Two surfaces, permanent	\$48.00
02160	Amalgam — Three surfaces, permanent	\$56.00
02161	Amalgam — Four or more surfaces, permanent	\$56.00
02952	Cast post and core in addition to crown	\$105.00
02954	Prefabricated post and core in addition to crown	\$105.00
02330	Resin — one surface, anterior	\$46.00

02331	Resin — two surfaces, anterior	\$55.00
02332	Resin — three surfaces, anterior	\$60.00
02335	Resin — four or more surfaces, anterior	\$60.00
02391	Resin-based composite-1 surf posterior	\$48.00
02392	Resin-based composite-2 surf posterior	\$57.00
02393	Resin-based composite-3 surf posterior	\$62.00

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 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 amount for three (3) surface composite filling.

Oral Surgery (Extractions)

Procedure	Description	Maximum Reimbursement
07240	*Removal of impacted tooth completely covered by bone	\$155.00
07220	*Soft tissue impaction	\$105.00
07230	*Partial bony impaction	\$130.00
07210	*Difficult extraction, tooth or retained root requiring some bone removal, flap and sutures	\$65.00
07111	Coronal remnants - deciduous tooth	\$35.00
07140	Extraction erupted tooth or exp	\$40.00

Oral Surgery (Other than Extractions)

Procedure	Description	Maximum Reimbursement
07510	Incision and drainage of periodontal abscess	\$35.00
07450	*Cyst removal	\$75.00
07285	Biopsy and examination of oral tissue	\$38.00

Periodontics

Procedure	Description	Maximum Reimbursement

04266	*Guided tissue regeneration	\$125.00
04341	*Periodontal scaling and root planning (per quadrant); at least 5 teeth per quadrant	\$50.00
04910	*Periodontal Prophy, max 5 treatments each per calendar year. Periodontal prophy counted toward the 5 treatments	\$55.00
04211	*Gingivectomy, per tooth	\$45.00
04210	*Gingivectomy, per quadrant	\$225.00
04260	*Osseous surgery (per quadrant); at least 5 teeth per quadrant	\$375.00

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.

Endodontics (Root Canal Therapy)

Procedure	Description	Maximum Reimbursement
03310	*Root canal therapy — anterior	\$300.00
03320	*Root canal therapy — bicuspid	\$375.00
03330	*Root canal therapy — molar	\$450.00
03220	Therapeutic pulpotomy	\$70.00

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.

If any combination of apicoectomy, root end amalgam and apical curettage is done on the same tooth by the same Dentist or Provider within a three (3) month period of root canal therapy, will not apply the Scheduled amounts for these services. GHI will apply a combined allowance for these services.

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.

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 Dentist or Provider will be deducted from the allowance for the root canal therapy or periodontal surgery.

Pulp capping is not covered.

Surgical replacement of rubber dam, recalcification of perforation, preparation of canal for post or dowels, and bleaching of discolored teeth are not covered.

Periapical Services

Procedure	Description	Maximum Reimbursement
03410	*Apicoectomy, single procedure	\$210.00
03426	*Apicoectomy, each additional root	\$105.00
03920	*Hemisection	\$70.00

Miscellaneous Procedures

Procedure	Description	Maximum Reimbursement
09310	Consultation with dental specialist	\$40.00

Repair and Replacement of Prosthetic Appliances

Procedure	Description	Maximum Reimbursement
05510	Repairing of broken denture, with or without broken teeth	\$80.00
05520	Replacing missing or broken teeth, complete denture, each tooth	\$50.00
05630	Replacing broken clasp	\$100.00
06930	Recementing fixed bridge	\$30.00
	Maximum repair allowance per family member per calendar year	\$200.00

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.

If the repair of a broken denture is performed in the same arch as the insertion of a full denture, GHI's allowance will be the Scheduled amount for the insertion of the new denture.

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.

You are not covered for the replacement or the substitution of appliances unless five (5) years have passed since the appliance was inserted.

If a fixed bridge and partial denture are inserted in the same arch, only the partial denture is covered

during the prosthetic replacement limitation period of five (5) years.

You are not covered for implants.

You are not covered for double or multiple abutments.

Crowns or pontics for attachment or clasp purposes are not covered unless the tooth is so broken down that it cannot be restored by fillings. A cantilever pontic used for attachment purposes is not covered.

Splints are not covered except when a missing tooth is being replaced. Only the portion replacing the missing tooth is covered.

Crowns used in splints for periodontal conditions are not covered.

Crown buildups done in connection with individual crowns and abutments are not covered.

Crowns and inlays used as abutments are not covered unless they are used as primary support for fixed appliances.

Precious metal material used in crowns is reimbursed at a base metal rate.

The allowance for a ceramic inlay/onlay is the maximum Scheduled amount for an amalgam filling.

Duplication, rebase or chairside reline to a denture is limited to one (1) per denture in a five year period. This applies to both full and partial dentures.

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.

Rebase or repair of new dentures are not covered until six (6) months after insertion.

Adjustment of appliances is not covered within one (1) year of insertion.

GHI does not cover services or appliances used solely as an adjunct to periodontal care.

Precision attachment, metal coping, tissue conditioning and stress breakers are not covered.

Cosmetic surgery and/or treatment is not covered unless medically necessary.

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.

Administration of Anesthesia

Procedure	Description	Maximum Reimbursement
09220	*General anesthesia, first 30 minutes	\$265.00
09221	*General anesthesia, additional 15 minutes	\$80.00

09241	*Intravenous sedation; first 30 minutes	\$265.00
09242	*Intravenous sedation; additional 15 minutes	\$80.00

General anesthesia must be rendered in connection with a covered service. IV sedation is covered when administered according to the American Dental Association guidelines.

Prosthetics — Predetermination required

(Including 12 months post-care)

Procedure	Description	Maximum Reimbursement
05110	*Complete dentures: Full permanent, upper jaw	\$580.00
05120	*Complete dentures: Full permanent, lower jaw	\$580.00
05211	*Upper partial denture— resin base (including any conventional clasps, rests and teeth)	\$350.00
05212	*Lower partial denture—resin base (including any conventional clasps, rests and teeth)	\$350.00
05213	*Upper partial denture—cast metal framework with resin denture bases	\$600.00
05214	*Lower partial denture—cast metal framework with resin denture bases	\$600.00
05281	*Removable unilateral partial denture with one piece cast metal	\$245.00

Adjustment of appliance is not covered within one year of insertion. Precision attachment, metal coping, tissue conditioning, and stress breakers are not covered.

Other Prosthetic Services

Procedure	Description	Maximum Reimbursement
05650	*Adding teeth to partial denture to replace natural teeth	\$75.00
05710	*Rebase full, upper jaw (lab processed)	\$220.00
05711	*Rebase full, lower jaw (lab processed)	\$220.00
05720	*Rebase partial, upper jaw (lab processed)	\$160.00
05721	*Rebase partial, lower jaw (lab processed)	\$160.00
05730	*Reline complete upper denture (chairside)	\$100.00
05731	*Reline complete lower denture (chairside)	\$100.00
05740	*Reline upper partial denture (chairside)	\$85.00
05741	*Reline lower partial denture (chairside)	\$85.00

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.

You are not covered for the replacement or substitution of appliances unless five (5) years have passed since the appliance was inserted.

If a fixed bridge and partial denture are inserted in the same arch, only the partial denture is covered during the prosthetic replacement limitation period of five (5) years.

Duplication, rebase or chairside relines to a denture is limited to one per-denture in a five year period. This applies to both full and partial dentures.

If a three surface inlay, crown or abutment is done on a tooth that has been filled within the last 6 months, GHI will deduct the schedule amount for the filling from its payment for the inlay, crown or abutment.

Bridge Pontics

Procedure	Description	Maximum Reimbursement
06210	*Cast metal	\$275.00
06211	*Pontic — cast predominately base metal	\$275.00
06212	*Pontic — cast noble metal	\$275.00
06240	*Porcelain fused to metal	\$300.00
06241	*Pontic — porcelain fused to predominately base metal	\$300.00
06242	*Pontic — porcelain fused to high noble metal	\$300.00

Crowns as Abutments

Procedure	Description	Maximum Reimbursement
02750	*Crown — Porcelain fused to high noble metal	\$400.00
02751	*Crown — Porcelain fused to predominately base metal	\$400.00
02752	*Crown — Porcelain fused to noble metal	\$400.00
02790	*Crown — Full cast, high noble metal	\$325.00
02791	*Crown — Full cast, predominately base metal	\$325.00
02792	*Crown — Full cast, noble metal	\$325.00
02920	*Recement crown	\$30.00
02960	*Labial veneer (lamine, chairside)	\$140.00
02961	*Labial veneer (resin laminate, lab processed)	\$340.00
02962	*Labial veneer (porcelain laminate, lab processed)	\$340.00
06720	*Crown — Resin with high noble metal	\$350.00

06721	*Crowns used as abutments, anterior or posterior: resin with predominately base metal	\$350.00
06722	*Crown — Resin with noble metal	\$350.00
06750	*Crown — Porcelain fused to high noble metal	\$400.00
06751	*Crowns used as abutments, anterior or posterior: porcelain fused to predominately base metal	\$400.00
06752	*Crown — Porcelain fused to noble metal	\$400.00

Crown buildups done in connection with individual crowns and abutments are not covered.

Each abutment and each pontic in a fixed bridge constitutes a unit in a bridge. You are not covered for implants.

Crowns or pontics for attachments or clasp purposes are not covered unless the tooth is so broken down that it cannot be restored by fillings. A cantilever pontic used for attachment purposes is not covered.

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 a completed, permanent service or appliance. Precious metal material used in crown is reimbursed at a base metal rate. Crowns used as splints for periodontal conditions 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 Scheduled amount for single crowns, not the Scheduled amount for a bridge abutment or splint.

The charge for cementation of a crown/inlay is included in the allowance for the crown/inlay.

Posts are only covered 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 build-ups including pins are not covered.

The allowance for chairside laminates for anterior teeth will be the comparable maximum composite Scheduled amount.

Inlays Used as Abutments

Procedure	Description	Maximum Reimbursement
06604	*Inlays — two surfaces, metallic	\$200.00
06605	*Inlays — three surfaces, metallic	\$325.00
06970	Cast post and core in addition to bridge retainer	\$95.00
06971	Cast post as part of bridge retainer	\$95.00
06972	Prefabricated post and core, in addition to bridge retainer	\$95.00

Crowns and inlays used as abutments are not covered unless they are used as primary support for fixed appliances.

The allowance for an onlay will be the schedule amount for a three surface inlay. If an onlay and three surface inlays are done on the same tooth on the same day, GHI's allowance will be the schedule amount for the three surface inlay. A separate allowance for the onlay will not be provided.

Orthodontic Services — Predetermination Required

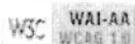
Procedure	Description	Maximum Reimbursement
08030	*Limited active orthodontia treatment	\$67.00
08399	*Appliance fee and diagnostic workup	\$550.00

Examination, study models, x-rays, diagnosis, construction and insertion of orthodontic appliances, including all previous prophylactic appliances, for tooth guidance, including multi-phasal orthodontia. Multi-Phasal Orthodontia services are included in your benefit under the administration of insertion of appliance up to a lifetime maximum of \$550.

Procedure	Description	Maximum Reimbursement
08599	*Active orthodontic treatment up to 20 months each treatment	\$67.00
08750	*Passive treatment up to a lifetime maximum of \$108 (per 6 months of treatment)	\$36.00

Your dentist should submit your regular initial appliance and workup fee as a separate charge with the code indicated.

*Requires Pre-Determination



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GHI PREFERRED DENTAL		2008	2009	
PROC CODE	DESCRIPTION	Fee Schedule	Fee Schedule	Comments
D0120	PERIODIC ORAL EXAM	\$19.00	\$19.00	
D0140	LIMITED ORAL EVALUATION	\$19.00	\$19.00	
D0145	ORAL EVAL PATIENT UNDER 3YRS OLD	\$21.00	\$21.00	
D0150	COMPREHENSIVE INITIAL ORAL EXAM.	\$22.00	\$22.00	
D0160	DETAIL ORAL EVAL-NEW PATIENT	\$20.00	\$20.00	
D0170	EMERGENCY ORAL EXAM	\$15.00	\$15.00	
D0180	COMPREH PERIODON EVAL-NEW PATIENT	\$21.00	\$21.00	
D0210	INTRAORAL COMPLETE SERIES	\$51.00	\$51.00	
D0220	INTRORAL PERIAPICAL-FIRST FILM	\$6.00	\$6.00	
D0230	INTRAORAL PERIAPICAL-EACH ADD FIL	\$5.00	\$5.00	
D0240	INTRORAL-OCCLUSAL FILM	\$11.00	\$11.00	
D0270	BITEWING XRAY-SINGLE FILM	\$7.00	\$7.00	
D0272	BITEWINGS-TWO FILMS	\$14.00	\$14.00	
D0273	BETEWINGS-THREE FILMS	\$21.00	\$21.00	
D0274	BITEWINGS-FOUR FILMS	\$28.00	\$28.00	
D0290	PASTERIOR-ANTERIOR OR LATERAL SKU	\$31.00	\$31.00	
D0321	OTHER TMJ , BY REPORT	\$36.00	\$36.00	
D0330	PANOREX X-RAY	\$35.00	\$35.00	
D0340	CAPHALOMETRIC FILM	\$26.00	\$35.00	Fee never increased since 1988 network introduction.
D0473	ACCESSION OF TISSUE	\$20.00	\$20.00	
D1110	PROPHYLAXIS-ADULT	\$37.00	\$37.00	
D1120	PROPHYLAXIS-CHILD	\$26.00	\$26.00	
D1201	PROPHYLAXIS-CHILD.PLUS FLUORIDE	\$42.00	\$42.00	
D1203	TOPICAL APPLICAT FLUORIDE-CHILD	\$16.00	\$16.00	
D1204	FLUORIDE EXC PROPHY ADULT	\$16.00	\$16.00	
D1205	FLUORIDE INC PROPHY ADULT	\$49.00	\$49.00	
D1206	TOPICAL FLUORIDE VARNISH	\$16.00	\$16.00	
D1351	SEALANT-PER TOOTH	\$22.00	\$22.00	
D1510	SPACE MAINTAINER-FIXED-UNILATERAL	\$85.00	\$120.00	Fee never increased since 1988 network introduction.
D1515	SPACE MAINTAINER-FIXED-BILATERAL	\$112.00	\$150.00	Fee never increased since 1988 network introduction.
D1520	SPACE MAINTAINER-REMOVABLE-UNILAT	\$85.00	\$120.00	Fee never increased since 1988 network introduction.
D1525	SPACE MAINTAIN-REMOVABLE-BILATERA	\$85.00	\$150.00	Fee never increased since 1988 network introduction.
D1550	RECEMENTATION OF SPACE MAINTAINER	\$30.00	\$40.00	Fee never increased since 1988 network introduction.
D2140	ONE SURF AMALGAM-PERMANENT	\$38.00	\$38.00	
D2150	TWO SURF AMALGAM-PERMANENT	\$48.00	\$48.00	
D2160	THREE SURF AMALGAM-PERMANENT	\$56.00	\$56.00	
D2161	FOUR OR MORE SURF AMALGAM-PERMANE	\$56.00	\$56.00	
D2330	RESIN-ONE SURFACE ANTERIOR	\$46.00	\$46.00	
D2331	RESIN-TWO SURFACES ANTERIOR	\$55.00	\$55.00	
D2332	RESIN-THREE SURFACES ANTERIOR	\$60.00	\$60.00	
D2335	RESIN 4 FILLINGS INCIS ANGLE ANTE	\$60.00	\$60.00	
D2390	RESIN-BASED COMPOSITE CROWN-ANTER	\$60.00	\$60.00	
D2391	RESIN-BASED COMPOSITE-1 SURF POST	\$48.00	\$48.00	
D2392	RESIN-BASED COMPOSITE-2 SURF POST	\$57.00	\$57.00	
D2393	RESIN-BASED COMPOSITE-3 SURF POST	\$62.00	\$62.00	
D2394	RESIN-BASED COMPOSITE-4 OR MORE S	\$62.00	\$62.00	
D2510	INLAY METALLIC ONE SURFACE	\$38.00	\$38.00	
D2520	INLAY,METALLIC-TWO SURFACES	\$200.00	\$200.00	
D2530	INLAY,METALLIC-THREE / MORE SURFA	\$325.00	\$325.00	
D2542	ONLAY-METALLIC -2 SURFACES	\$200.00	\$200.00	
D2543	ONLAY-METALLIC-3 SURFACES	\$325.00	\$325.00	
D2544	ONLAY-METALLIC - 4/MORE SURFACES	\$325.00	\$325.00	
D2610	INLAY PORC/CERAMIC. ONE SURFACE	\$38.00	\$38.00	
D2620	INLAY,PORCELAIN/CERAMIC-2 SURFACE	\$200.00	\$200.00	
D2630	INLAY,PORCELAIN/CERAMIC-3/MORE SU	\$325.00	\$325.00	
D2642	ONLAY-PORCELAIN/CERAMIC-2 SURFACE	\$200.00	\$200.00	
D2643	ONLAY-PORCELAIN/CERAMIC-3 SURFACE	\$325.00	\$325.00	
D2644	ONLAY-PORCELAIN/CERAMIC-4/MORE SU	\$325.00	\$325.00	
D2650	INLAY COMP. RESIN ONE SURFACE	\$38.00	\$38.00	
D2651	INLAY,COMPOSITE/RESIN-TWO SURFACE	\$200.00	\$200.00	
D2652	INLAY,COMPOSITE/RESIN-3/MORE SURF	\$325.00	\$325.00	
D2662	ONLAY-COMPOSITE/RESIN-2 SURF (LAB	\$200.00	\$200.00	

GHI PREFERRED DENTAL		2008	2009	
PROC CODE	DESCRIPTION	Fee Schedule	Fee Schedule	Comments
D2663	ONLAY-COMPOSITE/RESIN-3 SURF (LAB	\$325.00	\$325.00	
D2664	ONLAY-COMPOS/RESN-4/MORE SURF (LA	\$325.00	\$325.00	
D2710	CROWN- RESIN (INDIRECT)	\$150.00	\$225.00	Fee never increased since 1988 network introduction.
D2720	RESIN HIGH NOBLE METAL CR	\$350.00	\$350.00	
D2721	CROWN - RESIN W PREDOMIN BASE MET	\$350.00	\$350.00	
D2722	RESIN NOBLE METAL CR	\$350.00	\$350.00	
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	\$400.00	\$400.00	
D2750	PORCELAIN HIGH NOBLE CR	\$400.00	\$400.00	
D2751	CROWN-PORCEL TO PREDOMIN BASE MET	\$400.00	\$400.00	
D2752	PORCELAIN NOBLE METAL CR	\$400.00	\$400.00	
D2780	CROWN-3/4 CAST HIGH NOBLE	\$300.00	\$300.00	
D2781	CROWN-3/4 CAST PREDOM BASE MATAL	\$300.00	\$300.00	
D2782	CROWN 3/4 CAST NOBLE METAL	\$300.00	\$300.00	
D2783	CROWN 3/4 PORCELAIN/CERAMIC	\$300.00	\$300.00	
D2790	FULL CAST HIGH NOBLE CR	\$325.00	\$325.00	
D2791	CROWN-FULL CAST PREDOM BASE METAL	\$325.00	\$325.00	
D2792	FULL CAST NOBLE METAL CR	\$325.00	\$325.00	
D2794	CROWN - TITANIUM	\$325.00	\$325.00	
D2910	RECEMENT INLAY	\$20.00	\$30.00	Fee never increased since 1988 network introduction.
D2915	RECEMENT CAST/PREFABRIC POST & CO	\$20.00	\$30.00	Fee never increased since 1988 network introduction.
D2920	RECEMENT CROWN	\$20.00	\$30.00	Fee never increased since 1988 network introduction.
D2930	PREFAB STAINLESS STEEL CROWN, PRI	\$110.00	\$110.00	
D2931	PREFAB STAINLESS STEEL CROWN, PER	\$110.00	\$110.00	
D2932	PREFABRIC RESIN CROWN	\$100.00	\$100.00	
D2933	PREFABRIC STAINLESS STEEL CROWN	\$110.00	\$110.00	
D2934	PREFABRIC COAT STAINLESS STEEL CR	\$110.00	\$110.00	
D2951	PIN RETENT-PER TOOTH,ADD RESTORAT	\$20.00	\$20.00	
D2952	CAST & CORE ADD CROWN,INDIRECT FA	\$105.00	\$105.00	
D2954	PREFABRIC POST & CORE ADD TO CROW	\$105.00	\$105.00	
D2960	LABIAL VENEER(LAMINATE)-CHAIRSIDE	\$140.00	\$140.00	
D2961	LABIAL VENEER(RESIN LAMINATE)-LAB	\$340.00	\$340.00	
D2962	LABIAL VENEER(PORCELAIN LAMINATE)	\$340.00	\$340.00	
D2999	UNSPEC RESTORATION BY REPORT	\$1.00	\$1.00	
D3220	THERAPEUTIC PULPOTOMY	\$70.00	\$70.00	
D3230	PULPAL THERAPY-ANTERIOR PRIM TOOT	\$144.00	\$144.00	
D3240	PULPAL THERAPY-POSTERIOR PRIM TOO	\$245.00	\$245.00	
D3310	ROOT CANAL THERAPY-ONE CANAL	\$300.00	\$300.00	
D3320	ROOT CANAL THERAPY-TWO CANALS	\$375.00	\$375.00	
D3330	ROOT CANAL THERAPY-THREE CANALS	\$450.00	\$450.00	
D3346	RETREATMENT RCT-ONE CANAL	\$400.00	\$400.00	
D3347	RETREATMENT RCT-TWO CANALS	\$475.00	\$475.00	
D3348	RETREATMENT RCT-THREE CANALS	\$550.00	\$550.00	
D3351	APEXIF/RECALCIF-INITIAL VISIT	\$35.00	\$35.00	
D3352	APEXIF/RECALC-INTERIM MEDICAT REP	\$35.00	\$35.00	
D3353	APEX/RECAL-FINAL VISIT	\$35.00	\$35.00	
D3410	APICO/PERIRAD SURGERY-ANTERIOR	\$210.00	\$210.00	
D3421	APICO/PERIRAD SURGERY-BICUSID (1 ROOT)	\$210.00	\$210.00	
D3425	APICO/PERIRAD SURGERY-MOLAR (1 ROO	\$210.00	\$210.00	
D3426	APICO/PERIRAD SURGERY(EACH ADD RT	\$105.00	\$105.00	
D3430	RETROGRADE FILLING-PER ROOT	\$37.00	\$37.00	
D3450	ROOT AMPUTATION-PER ROOT	\$210.00	\$210.00	
D3920	HEMISECT-NOT INCLUD RT CANAL THER	\$70.00	\$70.00	
D4210	GINGIV/GINGIVO-4/MORE TEETH	\$225.00	\$225.00	
D4211	GINGIV/GINGIVO-1 TO 3 TEETH	\$45.00	\$45.00	
D4220	GINGIVAL CURETTAGE PER QUAD	\$40.00	\$40.00	
D4240	GINGI FLAP PROCEDURE 4/MORE TEETH	\$135.00	\$135.00	
D4241	GINGIVAL FLAP W/ROOT-1 TO 3 TEETH	\$27.00	\$27.00	
D4245	APICALLY POSITIONED FLAP	\$250.00	\$250.00	
D4249	CLINICAL CROWN LENGTH-HARD TISSUE	\$150.00	\$200.00	Very undervalued & not raised since 2003.
D4260	OSSEOUS SURGERY-4/MORE TEETH	\$375.00	\$375.00	
D4261	OSSEOUS SURGERY-1 TO 3 CONTIG TEE	\$75.00	\$75.00	
D4263	BONE REPLACEMENT GRAFT-1ST SITE	\$75.00	\$75.00	

GHI PREFERRED DENTAL		2008	2009	
PROC CODE	DESCRIPTION	Fee Schedule	Fee Schedule	Comments
D4264	BONE REPLACE GRAFT-EACH ADD IN QU	\$75.00	\$75.00	
D4266	GUIDE TISSUE REGENE-RESORB BARRIE	\$125.00	\$125.00	
D4267	GUIDE TISSUE REGENE-NONRESORB BAR	\$142.00	\$142.00	
D4268	GUIDED TISSUE REGENERATION PER QU	\$250.00	\$250.00	
D4270	PEDICLE SOFT TISS GRAFT PROCEDURE	\$50.00	\$50.00	
D4271	FREE SOFT TISSUE GRAFT PROCEDURE	\$120.00	\$120.00	
D4273	SUBEPIT CONNECT TISSUE GRAFT PROC	\$120.00	\$120.00	
D4274	DISTAL/PROXI WEDGE PROCEDURE	\$45.00	\$45.00	
D4276	COMBIN TISSUE & DOUBLE PEDICLE GR	\$120.00	\$120.00	
D4341	PERIODON SCAL& RT PLAN-PER QUADRA	\$50.00	\$50.00	
D4342	PERIODON SCAL & RT PLANN-1 TO 3 P	\$25.00	\$25.00	
D4355	FULL MONTH DEBRIDE PERIODONT EVAL	\$75.00	\$75.00	
D4381	LOCAL DELIVERY CHEMO AGENTS	\$30.00	\$30.00	
D4910	PERODONTAL MAINTENANCE	\$55.00	\$55.00	
D5110	COMPLETE UPPER DENTURE	\$480.00	\$580.00	State approved.
D5120	COMPLETE LOWER DENTURE	\$480.00	\$580.00	State approved.
D5130	IMMEDIATE UPPER DENTURE	\$500.00	\$620.00	State approved.
D5140	IMMEDIATE LOWER DENTURE	\$500.00	\$620.00	State approved.
D5211	PARTIAL UPPER-ACRYLIC BASE	\$330.00	\$350.00	State approved.
D5212	PARTIAL LOWER-ACRYLIC BASE	\$330.00	\$350.00	State approved.
D5213	PARTIAL UPPER-BASE/ACRYLIC	\$510.00	\$600.00	State approved.
D5214	PARTIAL LOWER BASE/ACRYLIC	\$510.00	\$600.00	State approved.
D5225	PARTIAL LOWER-FLEXIBLE BASE	\$510.00	\$600.00	State approved.
D5226	PARTIAL LOWER-FLEXIBLE BASE	\$510.00	\$600.00	State approved.
D5281	REMOVABLE UNILATERAL PARTIAL DENT	\$145.00	\$245.00	State approved.
D5410	ADJUST COMPLETE DENTURE-UPPER	\$25.00	\$25.00	
D5411	ADJUST COMPLETE DENTURE-LOWER	\$25.00	\$25.00	
D5421	ADJUST PARTIAL DENTURE UPPER	\$25.00	\$25.00	
D5422	ADJUST PARTIAL DENTURE-LOWER	\$25.00	\$25.00	
D5510	REPAIR BROKEN COMPLETE DENTURE BA	\$60.00	\$80.00	State approved.
D5520	REPLACE MISSING/BROKEN TEETH,COMP	\$35.00	\$50.00	State approved.
D5610	REPAIR RESIN DENTURE BASE	\$55.00	\$80.00	State approved.
D5620	REPAIR CAST FRAMEWORK	\$55.00	\$120.00	State approved.
D5630	REPAIR OR REPLACE BROKEN CLASP	\$75.00	\$100.00	State approved.
D5640	REPLACE BROKEN TEETH-PER TOOTH	\$50.00	\$50.00	
D5650	ADD TOOTH EXISTING PARTIAL DENTUR	\$50.00	\$75.00	State approved.
D5660	ADD CLASP TO EXIST PARTIAL DENTUR	\$80.00	\$100.00	State approved.
D5710	REBASE COMPLETE UPPER DENTURE	\$180.00	\$220.00	State approved.
D5711	REBASE COMPLETE LOWER DENTURE	\$180.00	\$220.00	State approved.
D5720	REBASE UPPER PARTIAL DENTURE	\$160.00	\$160.00	
D5721	REBASE LOWER PARTIAL DENTURE	\$160.00	\$160.00	
D5730	RELINE COMPLETE UPPER DENTURE	\$100.00	\$100.00	
D5731	RELINE COMPLETE LOWER DENTURE(CHA	\$100.00	\$100.00	
D5740	RELINE UPPER PARTIAL DENTURE	\$85.00	\$85.00	
D5741	RELINE LOWER PARTIAL	\$85.00	\$85.00	
D5750	RELINE UPPER COMPLETE DENTURE(LAB	\$160.00	\$200.00	State approved.
D5751	RELINE LOWER COMPLETE DENTURE(LAB	\$160.00	\$200.00	State approved.
D5760	RELINE UPPER PARTIAL DENTURE (LAB	\$145.00	\$145.00	
D5761	RELINE LOWER PARTIAL DENTURE (LAB	\$145.00	\$145.00	
D5860	OVERDENTURE COMPLETE	\$400.00	\$400.00	
D5861	OVERDENTURE PARTIAL	\$400.00	\$400.00	
D6210	CAST HIGH NOBLE PONTIC	\$275.00	\$275.00	
D6211	CAST BASE METAL PONTIC	\$275.00	\$275.00	
D6212	CAST NOBLE METAL PONTIC	\$275.00	\$275.00	
D6214	PONTIC-TITANIUM	\$300.00	\$300.00	
D6240	PORC/HIGH NOBLE METAL PONTIC	\$300.00	\$300.00	
D6241	PORCELIN BASE METAL PONTIC	\$300.00	\$300.00	
D6242	PORC/NOBLE METAL PONTIC	\$300.00	\$300.00	
D6245	PONTIC PORCELAIN/CERAMIC	\$300.00	\$300.00	
D6250	RESIN/HIGH NOBLE METAL PONTIC	\$300.00	\$300.00	
D6251	RESIN BASE METAL PONTIC	\$300.00	\$300.00	
D6252	RESIN/NOBLE METAL PONTIC	\$300.00	\$300.00	

GHI PREFERRED DENTAL		2008	2009	
PROC CODE	DESCRIPTION	Fee Schedule	Fee Schedule	Comments
D6520	INLAY-METALLIC-2 SURFACES	\$150.00	\$150.00	
D6530	INLAY-METALLIC-3 SURFACES	\$200.00	\$200.00	
D6543	ONLAY,METALLIC-THREE SURFACES	\$200.00	\$200.00	
D6544	ONLAY,METALLIC-FOUR OR MORE SURFA	\$200.00	\$200.00	
D6545	RETAINER-CAST METAL RESIN BONDED	\$135.00	\$135.00	
D6600	INLAY-PORCELAIN/CERAMIC,2 SURFACE	\$200.00	\$200.00	
D6601	INLAY-PORCELAIN/CERAMIC,3/MORE SU	\$325.00	\$325.00	
D6602	INLAY-CAST HIGH NOBLE METAL,2 SUR	\$200.00	\$200.00	
D6603	INLAY-CAST HIGH NOBLE METAL,3/M S	\$325.00	\$325.00	
D6604	INLAY-CAST PREDOM BASE METAL,2 SU	\$200.00	\$200.00	
D6605	INLAY-CAST PREDOM BASE METAL,3/MO	\$325.00	\$325.00	
D6606	INLAY-CAST NOBLE METAL,2 SURFACES	\$200.00	\$200.00	
D6607	INLAY-CAST NOBLE METAL 3/MORE SUR	\$325.00	\$325.00	
D6608	ONLAY-PORCELAIN/CERAMIC, 2 SURFAC	\$200.00	\$200.00	
D6609	ONLAY-PORCELAIN/CERAMIC,3+ SURFAC	\$325.00	\$325.00	
D6610	ONLAY-CAST HIGH NOBL MTL:2-SURFAC	\$200.00	\$200.00	
D6611	ONLAY-CAST HIGH NOBL MTL:3-SURFAC	\$325.00	\$325.00	
D6612	ONLAY-CAST PREDOM BASE MTL: 2-SUR	\$200.00	\$200.00	
D6613	ONLAY-CAST PREDOM BASE MTL:3+ SUR	\$325.00	\$325.00	
D6614	ONLAY-CAST NOBLE METAL: 2 SURFACE	\$200.00	\$200.00	
D6615	ONLAY-CAST NOBLE METAL:3+ SURFACE	\$325.00	\$325.00	
D6624	INLAY-TITANIUM	\$200.00	\$200.00	
D6634	ONLAY-TITANIUM	\$325.00	\$325.00	
D6720	RESIN/HIGH NOBLE METAL CR	\$350.00	\$350.00	
D6721	CROWN-RESIN W PREDOM BASE METAL	\$350.00	\$350.00	
D6722	PORC/HIGH NOBLE METAL CR	\$350.00	\$350.00	
D6740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	\$400.00	\$400.00	
D6750	PROC/HIGH NOBLE METAL CR	\$400.00	\$400.00	
D6751	CROWN-PORCELAIN FUSED PREDOM BASE	\$400.00	\$400.00	
D6752	PORC/NOBLE METAL CROWN	\$400.00	\$400.00	
D6780	CROWN-3/4 CAST HIGH NOBLE METAL	\$215.00	\$215.00	
D6781	CROWN 3/4 CAST BASE METAL	\$215.00	\$215.00	
D6782	CROWN 3/4 CAST NOBLE METAL	\$215.00	\$215.00	
D6790	FULL CAST HIGH NOBLE METAL CR	\$325.00	\$325.00	
D6791	CROWN-FULL CAST PREDOMIN BASE MET	\$325.00	\$325.00	
D6792	FULL CAST NOBLE METAL CR	\$325.00	\$325.00	
D6794	CROWN-TITANIUM	\$400.00	\$400.00	
D6930	RECEMENT BRIDGE	\$30.00	\$30.00	
D6970	POST & CORE ADD FIXED PARTIAL DEN	\$95.00	\$95.00	
D6971	CAST POST - PART OF RETAINER	\$95.00	\$95.00	
D6972	PREFAB POST & CORE,ADD BRIDGE RET	\$95.00	\$95.00	
D7111	CORONAL REMNANTS-DECIDUOUS TOOTH	\$35.00	\$35.00	
D7130	ROOT REMOVAL - EXPOSED ROOTS	\$30.00	\$30.00	
D7140	EXTRACTION ERUPTED TOOTH OR EXP	\$40.00	\$40.00	
D7210	SURGICAL-EXTRACTION	\$65.00	\$65.00	
D7220	SOFT TISSUE IMPACTION	\$105.00	\$105.00	
D7230	PARTIAL BONY IMPACTION	\$130.00	\$130.00	
D7240	FULL BONY IMPACTION	\$155.00	\$155.00	
D7241	FULL BONY IMPACTION-UNUSUAL	\$155.00	\$155.00	
D7250	SURGICAL REMOVAL RESIDUAL TOOTH R	\$50.00	\$50.00	
D7260	ORAL ANTRAL FISTUAL CLOSURE	\$100.00	\$100.00	
D7261	PRIMARY CLOSURE SINUS PERFORATION	\$75.00	\$75.00	
D7270	TOOTH REIMPL/STABIL DISPLACE TOOT	\$50.00	\$50.00	
D7280	SURGICAL ACCESS UNERUPTED TOOTH	\$125.00	\$125.00	
D7281	SURGICAL EXPOSURE IMPACT/UNERUPT	\$125.00	\$125.00	
D7282	MOBLIZATION ERUPTED/MALPOSIT TOOT	\$125.00	\$125.00	
D7285	BIOPSY ORAL TISSUE- HARD	\$38.00	\$38.00	
D7286	BIOPSY ORAL TISSUE- SOFT	\$38.00	\$38.00	
D7290	SURGICAL REPOSITIONING TEETH	\$50.00	\$50.00	
D7291	TRANSSS FIBER/SUPRA CRESTAL FIBER	\$27.00	\$37.00	Fee never increased since 1988 network introduction.
D7310	ALVEO CONJUNCT W/EXTRACT-4/MORE T	\$50.00	\$60.00	Fee never increased since 1988 network introduction.
D7311	ALVEO CONJUNCT W/EXTRACT-1 TO 3 T	\$10.00	\$20.00	Fee never increased since 1988 network introduction.

GHI PREFERRED DENTAL		2008	2009	
PROC CODE	DESCRIPTION	Fee Schedule	Fee Schedule	Comments
D7320	ALVEO NOT CONJUNCT W/EXTRACT-4/MO	\$50.00	\$100.00	Fee never increased since 1988 network introduction.
D7321	ALVEOL CONJUNCT W/EXTRACT-1 TO 3	\$10.00	\$50.00	Fee never increased since 1988 network introduction.
D7340	VESTIBULOPLASTY-RIDGE EXTENSION	\$100.00	\$150.00	Fee never increased since 1988 network introduction.
D7350	VESTIBULOPLASTY-RIDGE EXTENSION	\$100.00	\$200.00	Fee never increased since 1988 network introduction.
D7410	EXCISION BENIGN LESION UP TO 1.25	\$75.00	\$85.00	Fee never increased since 1988 network introduction.
D7411	EXCISION BENIGN LESION GREATER 1.	\$100.00	\$100.00	
D7412	EXCISION ON BENIGN LESION,COMPLIC	\$100.00	\$100.00	
D7413	EXCISION MALIGNANT LESION UP 1.25	\$75.00	\$75.00	
D7414	EXCISION MALIGNANT LESION GREAT1.	\$100.00	\$100.00	
D7415	EXCISION MALIGNANT LESION,COMPLIC	\$100.00	\$100.00	
D7430	EXCISION OF TUMOR-BENIGN-SMALL	\$75.00	\$75.00	
D7440	EXCISION OF MALIGNANT TUMOR-TO 1.	\$75.00	\$75.00	
D7441	EXCISION OF MALIGNANT TUMOR>1.25C	\$100.00	\$100.00	
D7450	REMOVAL ODONTOGENIC CYST/TUMOR-1.	\$75.00	\$75.00	
D7451	REMOVE ODONTO CYST/TUMOR-GREAT 1.	\$100.00	\$100.00	
D7460	REMOVE BENIGN NONODON LESION UP1.	\$75.00	\$75.00	
D7461	REMOVE BENIGN NONODO LES GREAT 1.	\$100.00	\$100.00	
D7471	REMOVAL LATERAL EXOSTOSIS	\$75.00	\$75.00	
D7472	REMOVAL TORUS PALATINUS	\$100.00	\$100.00	
D7473	REMOVAL TORUS MANDIBULARIS	\$100.00	\$100.00	
D7485	SURG REDUCTION OSSEOUS TUBEROSITY	\$75.00	\$75.00	
D7510	INCISION & DRAIN ABSCEES-INTRAORA	\$35.00	\$35.00	
D7511	INCISION AND DRAINAGE OF ABSCESS	\$45.00	\$45.00	
D7520	INCIS & DRANIAGE ABSCESS-EXTRAORA	\$35.00	\$35.00	
D7610	FRACT-SIMPLE-OPEN REDUCT-MAXL	\$300.00	\$300.00	
D7620	FRACT SIMPLE CLSD REDUC MAX	\$300.00	\$300.00	
D7630	FRACT SIMPLE OPEN REDUC MAND	\$450.00	\$450.00	
D7640	FRACT-SIMPLE-CLSD REDUCT-MAND	\$350.00	\$350.00	
D7650	FRACT SIMPLE OPEN ZYGOMATIC	\$300.00	\$300.00	
D7660	FRACT SIMPLE CLSD ZYGOMATIC	\$100.00	\$100.00	
D7670	ALVEO-CLOSE REDUCT,STABLE TEETH	\$200.00	\$200.00	
D7671	ALVEO-OPEN REDUCT,STABLE TEETH	\$300.00	\$300.00	
D7710	FRACTURE-COMPOUND-OPEN-MAXILLA	\$450.00	\$450.00	
D7720	FRACT COMP CLSD MAXILLA	\$300.00	\$300.00	
D7730	FRACTURE-COMPOUND-OPEN-MAND	\$450.00	\$450.00	
D7740	FRACTURE-COMPOUND-CLOSED-MAND	\$350.00	\$350.00	
D7750	FRACTURE-COMPOUND-OPEN-ZYGOMAT	\$300.00	\$300.00	
D7760	FRACTURE-COMPOUND-CLSD-ZYGOMAT	\$1.00	\$1.00	
D7770	ALVEO-OPEN REDUCT STABLE TEETH	\$450.00	\$450.00	
D7771	ALVEO-CLOSE REDUCT STABLE TEETH	\$300.00	\$300.00	
D7810	TMJ OPEN REDUCTION OF FRACTURE	\$150.00	\$150.00	
D7820	TMJ CLOSED REDUCTION OF FRACTURE	\$75.00	\$75.00	
D7960	FRENULECTOMY-SEPARATE PROCEDURE	\$100.00	\$100.00	
D7963	FRENULOPLASTY	\$100.00	\$100.00	
D7970	EXCISION HYPERPLAST TISSUE,PER AR	\$50.00	\$50.00	
D7971	EXCISION PERICORONAL GINGIVAL	\$27.00	\$27.00	
D7972	SURGICAL REDUCT FIBROUS TUBEROSIT	\$50.00	\$50.00	
D9110	PALLIATIVE EMERGENCY TREATMENT	\$23.00	\$23.00	
D9220	DEEP SEDAT/GENE ANEST-FIRST 30 MI	\$265.00	\$265.00	
D9221	DEEP SEDAT/GENE ANEST-EACH ADD 15	\$80.00	\$80.00	
D9241	INTRAV SEDAT/ANALG-FIRST 30 MINS	\$265.00	\$265.00	
D9242	INTRAV SEDAT/ANALG-EACH ADD 15 MI	\$80.00	\$80.00	
D9310	CONSULTATION-PER SESSION	\$40.00	\$40.00	
D9410	HOUSE CALL	\$20.00	\$50.00	Fee never increased since 1988 network introduction.
D9420	HOSPITAL CALL	\$45.00	\$75.00	Fee never increased since 1988 network introduction.
D9430	OFFICE VISIT OBSERVATION-NO OTHER	\$20.00	\$30.00	Fee never increased since 1988 network introduction.
D9440	OFF VISIT-AFTER REGULARLY SCHEDUL	\$29.00	\$50.00	Fee never increased since 1988 network introduction.
D9941	FABRIC_ATHLETIC MOUTH GUARD	\$50.00	\$70.00	Fee never increased since 1988 network introduction.
D9951	OCCUSAL ADJUSTMENT-LIMITED	\$22.00	\$44.00	Fee never increased since 1988 network introduction.
D9952	OCCUSAL ADJUSTMENT-COMPLETE	\$55.00	\$70.00	Fee never increased since 1988 network introduction.