GEHA Connection Dental Federal®

https://www.gehadental.com

2017

A National Dental PPO Plan

Who may enroll in this Plan: All Federal employees and annuitants in the United States and overseas who are eligible to enroll in the Federal Employees Dental and Vision Insurance Program

This Plan has 6 enrollment regions, including international; please see the end of this brochure to determine your region and corresponding rates.

Enrollment Options for this Plan:

- **High Option – Self Only**
- **High Option – Self Plus One**
- **High Option – Self and Family**
- **Standard Option – Self Only**
- **Standard Option – Self Plus One**
- **Standard Option – Self Plus Family**

Group Number AA

ACCREDITED

Dental Network
Expires 08/01/2019

URAC accreditation:
GEHA for Dental Network

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
www.opm.gov/healthcare-insurance

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The Act directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants, and their eligible family members. In response to the legislation, OPM established the Federal Employees Dental and Vision Insurance Program (FEDVIP). OPM has contracted with dental and vision insurers to offer an array of choices to Federal employees and annuitants.

This brochure describes the benefits of GEHA Connection Dental Federal® under Government Employees Health Association, Inc.'s contract OPM01-FEDVIP-01AP-8 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

GEHA Connection Dental Federal
P. O. Box 2336
Independence, MO 64051-2336
(877) GEHA-DEN or (877) 434-2336
www.gehadental.com

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your benefits.

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits, if they are listed on the coverage. You and your family members do not have a right to benefits that were available before January 1, 2017, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each carrier annually. Rates are shown at the end of this brochure.

GEHA is responsible for the selection of in-network providers in your area. Contact us at (877) 434-2336 for the names of participating providers or to request a provider directory. You may also view or request the most current directory via our website at www.gehadental.com. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not for a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in-network. If your provider is not currently participating in the provider network, you may nominate him or her to join. Nomination forms are available on our website, or call us and we will have a form sent to you. You cannot change plans, outside of Open Season, because of changes to the provider network.

Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If you require the services of a specialist and one is not available in your area, please contact us for assistance.

This GEHA Connection Dental Federal® plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program.

We want you to know that protecting the confidentiality of your individually identifiable health information is of the utmost importance to us. To review full details about our privacy practices, our legal duties, and your rights, please visit our website, www.gehadental.com. If you do not have access to the internet or would like further information, please contact us by calling (877) 434-2336.

Discrimination is Against the Law

GEHA Connection Dental Federal complies with all applicable Federal civil rights laws, to include both Title VII and Section 1557 of the ACA. Pursuant to Section 1557, GEHA Connection Dental Federal does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex (including pregnancy and gender identity).

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FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas, regional dental Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) plans, and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Visit www.opm.gov/healthcare-insurance/dental-vision/ for more information.
Enroll Through BENEFEDS	You enroll online at www.BENEFEDS.com. Please see Section 2, Enrollment, for more information.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2016 Open Season, your coverage will begin on January 1, 2017. Premium deductions will start with the first full pay period beginning on/after January 1, 2017. You may use your benefits as soon as your enrollment is confirmed.
Dual Enrollment	If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.
Pre-Tax Salary Deduction for Employees	Employees automatically pay premiums through payroll deductions using pre-tax dollars. Annuitants automatically pay premiums through annuity deductions using post-tax dollars.
Annual Enrollment Opportunity	Each year, an Open Season will be held, during which you may enroll or change your dental and/or vision plan enrollment. This year, Open Season runs from November 14, 2016 through midnight EST December 12, 2016. You do not need to re-enroll each Open Season unless you wish to change plans or plan options; your coverage will continue from the previous year. In addition to the annual Open Season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2, Enrollment, for more information.
Continued Group Coverage After Retirement	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may also be able to continue enrollment after your death. Please see Section 1, Eligibility, for more information.
Waiting Period	The only waiting period is for orthodontic services. To meet this requirement, the person receiving the services must be continuously enrolled in this dental plan for the entire waiting period.

How We Have Changed For 2017

Changes for High Option only

The High Option annual benefit maximum for combined Class A, Class B and Class C covered services increased to $35,000 per person.

The High Option waiting period has been removed on Class D orthodontic services.

Changes for High Option and Standard Option

Premium Increase – Your premiums will increase 2% on the High Option and 3% on the Standard Option in 2017.

Discrimination is Against the Law

The FEDVIP Plan complies with all applicable Federal civil rights laws, to include both Title VII and Section 1557 of the ACA. Pursuant to Section 1557 the FEDVIP Plan does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex (including pregnancy and gender identity).

FSAFEDS/High Deductible Health Plans and FEDVIP - Changes to FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA) are on pages 9-10.

Coordination of Benefits – When we are secondary or tertiary (third) payor, our payment will be the lesser of the following:

- Regular benefits; or
- The remaining balance which when added to the other carrier(s') payment will not exceed the dentist billed amount or negotiated rate.

Federal Laws – Federal Laws supersede State Laws including, but not limited to; coordination of benefits, subrogation, claim processing, provider filing and provider processing.

We added the following procedure codes:

D1575 Distal Shoe Space Maintainer – Fixed – Unilateral

D4346 Scaling inpresence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation - *Limited to a maximum of once every 2 Calendar Years and not covered if done within 24 months of periodontal scaling and root planing*

D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure - *Limited to a maximum of once every 2 Calendar Years and not covered if done within 24 months of periodontal scaling and root planing*

D8040 Limited orthodontic treatment of adult dentition

Occlusal guard - *treatment is for bruxism or to protect the teeth from grinding, chipping or fracture. An occlusal guard for temporomandibular joint dysfunction or other non dental related treatment is not covered.*

Implant services - Implant services are limited to an annual maximum of $2,500 per covered person included in the annual benefit maximum.

General Exclusions - Service or supplies furnished by yourself, household members or immediate relatives, such as spouse, parents, children, brothers or sisters, by blood, marriage, or adoption.

Section 1 Eligibility

Federal Employees

If you are a Federal or U.S. Postal Service employee, you are eligible to enroll in FEDVIP, if you are eligible for the Federal Employees Health Benefits (FEHB) Program or the Health Insurance Marketplace (Exchange) and your position is not excluded by law or regulation, you are eligible to enroll in FEDVIP. Enrollment in the FEHB Program or a Health Insurance Marketplace (Exchange) plan is not required.

Federal Annuitants

You are eligible to enroll if you:

- retired on an immediate annuity under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS) or another retirement system for employees of the Federal Government;
- retired for disability under CSRS, FERS, or another retirement system for employees of the Federal Government.

Your FEDVIP enrollment will continue into retirement if you retire on an immediate annuity or for disability under CSRS, FERS or another retirement system for employees of the Government, regardless of the length of time you had FEDVIP coverage as an employee. There is no requirement to have coverage for 5 years of service prior to retirement in order to continue coverage into retirement, as there is with the FEHB Program.

Your FEDVIP coverage will end if you retire on a Minimum Retirement Age (MRA) + 10 retirement and postpone receipt of your annuity. You may enroll in FEDVIP again when you begin to receive your annuity.

Advise BENEFEDS of your new payroll office number.

Survivor Annuitants

If you are a survivor of a deceased Federal/U.S. Postal Service employee or annuitant and you are receiving an annuity, you may enroll or continue the existing enrollment.

Compensationers

A compensationer is someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation Programs (OWCP) due to an on-the-job injury/illness who is determined by the Secretary of Labor to be unable to return to duty. You are eligible to enroll in FEDVIP or continue FEDVIP enrollment into compensation status.

Family Members

Eligible family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

FEDVIP rules and FEHB rules for family member eligibility are **NOT** the same. For more information on family member eligibility visit the website at www.opm.gov/healthcare-insurance/dental-vision/ or contact your employing agency or retirement system.

Not Eligible

The following persons are not eligible to enroll in FEDVIP, regardless of FEHB eligibility or receipt of an annuity or portion of an annuity:

- Deferred annuitants
- Former spouses of employees or annuitants
- FEHB Temporary Continuation of Coverage (TCC) enrollees
- Anyone receiving an insurable interest annuity who is not also an eligible family member

Discrimination is Against the Law

The FEDVIP Plan complies with all applicable Federal civil rights laws, to include both Title VII and Section 1557 of the ACA. Pursuant to Section 1557, the FEDVIP Plan does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex (including pregnancy and gender identity).

Section 2 Enrollment

Enroll Through BENEFEDS

You must use BENEFEDS to enroll or change enrollment in a FEDVIP plan. BENEFEDS is a secure enrollment website (www.BENEFEDS.com) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not want to change plans, **your enrollment will continue automatically. Please Note:** Your plan's premiums may change for 2017.

Note: You cannot enroll or change enrollment in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, PostalEase, EBIS, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

Enrollment Types

Self Only: A Self Only enrollment covers only you as the enrolled employee or annuitant. You may choose a Self Only enrollment even though you have a family, however, your family members will not be covered under FEDVIP.

Self Plus One: A Self Plus One enrollment covers you as the enrolled employee or annuitant plus one eligible family member whom you specify. You may choose a Self Plus One enrollment even though you have additional eligible family members, but the additional family members will not be covered under FEDVIP.

Self and Family: A Self and Family enrollment covers you as the enrolled employee or annuitant and all of your eligible family members. You must list all eligible family members when enrolling.

Dual Enrollment

If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee or annuitant, you may enroll in a dental and/or vision plan during the November 14, 2016 through midnight EST December 12, 2016 Open Season. Coverage is effective January 1, 2017.

During future annual Open Seasons, you may enroll in a plan, or change or cancel your dental and/or vision coverage. The effective date of these Open Season enrollments and changes will be set by OPM. If you want to continue your current enrollment, do nothing. **Your enrollment carries over from year to year, unless you change it.**

New hire/Newly eligible

You may enroll within 60 days after you become eligible as:

- a new employee;
- a previously ineligible employee who transferred to a covered position;
- a survivor annuitant if not already covered under FEDVIP; or
- an employee returning to service following a break in service of at least 31 days.

Your enrollment will be effective the first day of the pay period following the one in which BENEFEDS receives and confirms your enrollment.

Qualifying Life Event

A qualifying life event (QLE) is an event that allows you to enroll, or if you are already enrolled, allows you to change your enrollment outside of an Open Season.

The following chart lists the QLEs and the enrollment actions you may take:

Qualifying Life Event	From Not Enrolled to Enrolled	Increase Enrollment Type	Decrease Enrollment Type	Cancel	Change from One Plan to Another
Marriage	Yes	Yes	No	No	Yes
Acquiring an eligible family member (non-spouse)	No	Yes	No	No	No
Losing a covered family member	No	No	Yes	No	No
Losing other dental/vision coverage (eligible or covered person)	Yes	Yes	No	No	No
Moving out of regional plan's service area	No	No	No	No	Yes
Going on active military duty, non-pay status (enrollee or spouse)	No	No	No	Yes	No
Returning to pay status from active military duty (enrollee or spouse)	Yes	No	No	No	No
Returning to pay status from Leave without pay	**Yes (if enrollment cancelled during LWOP)**	No	No	No	**Yes (if enrollment cancelled during LWOP)**
Annuity/ compensation restored	Yes	Yes	Yes	No	No
Transferring to an eligible position*	No	No	No	Yes	No

*Position must be with a Federal agency that provides dental and/or vision coverage with 50 percent or more employer-paid premium and you elect to enroll.

The timeframe for requesting a QLE change is from 31 days before to 60 days after the event. There are two exceptions:

- There is no time limit for a change based on moving from a regional plan's service area; and
- You cannot request a new enrollment based on a QLE before the QLE occurs, except for enrollment because of the loss of dental or vision insurance. You must make the change no later than 60 days after the event.

Generally, enrollments and enrollment changes made based on a QLE are effective on the first day of the pay period following the one in which BENEFEDS receives the enrollment or change. BENEFEDS will send you confirmation of your new coverage effective date.

Once you enroll in a plan, your 60-day window for that type of plan ends, even if 60 calendar days have not yet elapsed. That means once you have enrolled in either plan, you cannot change or cancel that particular enrollment until the next Open Season, unless you experience a QLE that allows such a change or cancellation.

This is a one time opportunity. Once you make an election, you may not change your elected plan until the next Open Season.

Canceling an enrollment

You may cancel your enrollment only during the annual Open Season. An eligible family member's coverage also ends upon the effective date of the cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the Open Season effective date.

When Coverage Stops

Coverage ends when you:

- no longer meet the definition of an eligible employee or annuitant;
- begin a period of non-pay status or pay that is insufficient to have your FEDVIP premiums withheld and you do not make direct premium payments to BENEFEDS;
- are making direct premium payments to BENEFEDS and you stop making the payments; or
- cancel the enrollment during Open Season.

Coverage for a family member ends when:

- you as the enrollee lose coverage; or
- the family member no longer meets the definition of an eligible family member.

Continuation of Coverage

Under FEDVIP, there is no 31-day extension of coverage. The following are also NOT available under the FEDVIP plans:

- Temporary Continuation of Coverage (TCC);
- spouse equity coverage; or
- right to convert to an individual policy (conversion policy).

FSAFEDS/High Deductible Health Plans and FEDVIP

If you are planning to enroll in an FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA), you should consider how coverage under a FEDVIP plan will affect your annual expenses, and thus the amount that you should allot to an FSAFEDS account. Please note that insurance premiums are not eligible expenses for either type of FSA.

If you have an HCFSA or LEX HCFSA FSAFEDS account and you haven't exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over up to $500 of unspent funds into another health care or limited expense account for the subsequent year. To be eligible for carryover, you must be employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31. You must also actively re-enroll in a health care or limited expense account during the NEXT Open Season to be carryover eligible. Your re-enrollment must be for at least the minimum of $100. If you do not re-enroll, or if you are not employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st, your funds will not be carried over.

Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense and file a claim in the time period permitted. This is known as the "Use-it-or-Lose-it" rule. Carefully consider the amount you will elect.

For a health care or limited expense account, each participant must contribute a minimum of $100 to a maximum of $2,550.

Current FSAFEDS participants must re-enroll to participate next year. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-866-353-8058.

GEHA will transmit plan payment information for members that enroll in an FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA) to the FSAFEDS carrier. Members that participate are not required to submit claims on behalf of the GEHA Connection Dental Federal® plan to be reimbursed.

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you can use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB and FEDVIP plans.

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation

We will send you an identification (ID) card when you enroll. You must show it whenever you receive services from a plan provider.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (877) 434-2336 or write us at GEHA Connection Dental Federal, P.O. Box 2336, Independence, MO 64051-2336.

Existing members will not receive new ID cards unless otherwise requested.

You may also print a temporary ID card after signing in to your member account on our website: www.gehadental.com.

It is important to bring your FEDVIP and FEHB identification cards to every dental appointment because most FEHB plans offer some level of dental benefits separate from your FEDVIP coverage. Presenting both identification cards can ensure that you receive the maximum allowable benefit under both Programs.

Where You Get Covered Care

You may get care from any "covered provider." However, if you use our preferred providers, you may pay less because a preferred provider has agreed to limit charges to our maximum allowed charge for covered services.

Plan Providers

Each covered person has the right to choose any licensed dental practitioner. We list plan providers in the provider directory, which we update periodically. The list is on our website at www.gehadental.com. You may also call us at (877) 434-2336 for help in locating a preferred provider.

In-Network

Care that you receive from an in-network preferred provider (PPO). To obtain care, simply select a provider and make an appointment. Referrals to a specialist are not necessary. The plan does not require you to see a primary care provider before seeing a specialist. Information on participating dentists can be obtained free of charge. Visit our website at www.gehadental.com or call (877) 434-2336.

The list of preferred providers is subject to change. Before you receive care, it is your responsibility to verify with the preferred provider that the provider currently participates at the office location where you will be seen.

GEHA does not guarantee that preferred providers are available for all specialties, are available in all areas or that the Connection Dental Maximum Allowable Charge is less than what you might obtain from non-preferred providers.

Out-of-Network

Care that you receive from a provider that does not participate in our network of providers. GEHA reimburses for covered dental care from any covered provider. Non-PPO providers have no agreement to limit what they will bill you.

Pre-Treatment Estimate

The plan does not require pre-treatment estimates of benefits. GEHA will respond to a request to pre-determine services with an estimate of covered service, which is not a guarantee of payment since future changes such as changes in your enrollment or eligibility under the plan may affect benefits. We encourage you to ask your provider to request a pre-treatment estimate for any extensive treatment. By obtaining a pre-treatment estimate, you and your dental provider will have an estimate before treatment begins of what will be covered and how it will be paid. This information can be valuable to you in making an informed decision on how to proceed with treatment and can help protect you from unexpected out-of-pocket costs should the treatment plan not be covered.

To obtain a pre-determination, the dentist should submit a completed dental pre-treatment estimate claim form that itemizes the proposed procedure codes, charge for each procedure along with a pre-treatment plan, radiographic image and any other diagnostic materials.

First Payor

When you visit a provider who participates with both your FEHB plan and your FEDVIP plan, the FEHB plan will pay benefits first. The FEDVIP plan's allowance will be the prevailing charge, in these cases. You are responsible for the difference between the FEHB and FEDVIP payments and the FEDVIP plan allowance. We are responsible for facilitating the process with the primary FEHB first payor.

It is important to bring your FEDVIP and FEHB identification cards to every dental appointment because most FEHB plans offer some level of dental benefits separate from your FEDVIP coverage. Presenting both identification cards can ensure that you receive the maximum allowable benefit under each Program.

Coordination of Benefits

We will coordinate benefit payments with the payment of benefits under other group health benefits coverage you may have and the payment of dental costs under no-fault insurance that pays benefits without regard to fault. We determine which non-FEHB coverage is primary according to National Association of Insurance Commissioners' (NAIC) guidelines.

For example, if your spouse has other group dental coverage on the family in addition to this plan and your FEHB plan, your spouse's plan would pay first for your spouse's charges, your FEHB plan would pay second and this plan would pay third.

We may request that you verify/identify your health insurance plan(s) annually or at the time of service. You may call or mail other coverage information or report it online at www.gehadental.com/cob.

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We will consider any benefits payable by your FEHB medical plan before we calculate benefits payable by us. In addition to benefits payable by your FEHB medical plan, if you or your covered dependents have other dental coverage, you must tell GEHA. When we are secondary or tertiary (third) payor, our payment will be the lesser of the following:

- Regular benefits; or
- The remaining balance which when added to the other carrier(s') payment will not exceed the dentist billed amount or negotiated rate.

There is no change in benefit limits or maximums when we are the secondary payor.

For example:

Primary Carrier(s') payment(s), GEHA is secondary or tertiary	In-Network
Billed Amount	$165.00
GEHA's Allowable	$139.00 ($165 - $26 difference)
Primary Carrier(s') Payment(s)	$23.00
GEHA's Regular Benefit	$111.20 ($139 x 80%)
GEHA's Payment	$111.20
Patient's Responsibility	$4.80

You are not responsible for the $26.00, difference between the billed amount and the plan allowance. When you use an in-network dentist, the dentist cannot bill you for this amount.

Primary Carrier(s') payment(s), GEHA is secondary or tertiary	Out-of-Network
Billed Amount	$165.00
GEHA's Allowable	$139.00 ($165 - $26 difference)
Primary Carrier(s') Payment(s)	$23.00
GEHA's Regular Benefit	$111.20 ($139 x 80%)
GEHA's Payment	$111.20
Patient's Responsibility	$30.80

You are responsible for the $30.80, the difference between the billed amount, less the primary carrier(s') payment(s), less our payment. When you use an out-of-network dentist, the dentist can bill you up to the billed amount.

If your primary payor requires a pre-determination or requires that you use designated facilities for benefits to be approved, it is your responsibility to comply with these requirements. In addition, you must file the claim with your primary payor within the required time period. If you fail to comply with any of these requirements and the primary payor denies benefits, we will pay secondary benefits based on an estimate of what the primary carrier would have paid if you had followed their requirements.

Please see Section 4, Your Cost For Covered Services, for more information about how we pay claims.

Rating Areas

Your rates are determined based on where you live. This is called a rating area. If you move, you must update your address through BENEFEDS at www.BENEFEDS.com or by phone at (877) 888-3337. Your rates might change because of the move.

Limited Access Area

If you live in an area that does not have adequate access to in-network providers as determined by your 5-digit ZIP code and you receive covered services from an out-of-network provider, we will base our plan allowance on the 75th percentile of standard healthcare prevailing fees. You are responsible for any difference between the amount billed and our payment. For a list of our limited access areas, call (877) 434-2336.

Alternate Benefit

In some cases, you and your dental practitioner have a choice of treatment options. In an effort to keep your dental premiums affordable and assure you have coverage for the most common types of dental treatment, the dental plan limits benefits to the maximum allowable charge for the least costly covered service that accomplishes a result that meets accepted standards of professional dental care as determined by us.

If you or your dental practitioner should choose a more costly treatment or service, we will limit benefits payable to the benefit that would have been payable if the least costly covered service had been provided. This is called the alternate benefit. Any difference between the alternate benefit and the charge actually incurred is your responsibility, including any applicable coinsurance. In Section 5, services listed with an asterisk (*) often have the choice of a lower cost treatment. If you or your dental provider should choose this treatment or service, we will allow the lower cost alternative benefit unless evidence is submitted with the bill to explain why the less expensive treatment could not be done.

We decide the alternative benefit for covered services when we receive the claim. To avoid incurring expenses we will not cover, we encourage you to request a pre-treatment estimate of benefits before treatment begins.

Dental Review

Some services require additional information in order to determine if the services are covered or subject to an alternative benefit. Radiographic images are required for crowns, periodontal procedures, inlays/onlays, anterior and multiple fillings, crown build-ups and implants. The complete treatment plan is also needed for implants. Charting is required for periodontal procedures. The date of prior placement is required for replacement dentures, partials, crowns and bridges. The degree and classification of malocclusion is required for orthodontics.

Example 1 Crown – A pre-operative radiograph image is required for a crown to determine if services are for restorative purposes and necessary due to decay or tooth fracture and evidence is presented showing the tooth cannot be adequately restored with an amalgam or composite filling.

Example 2 Implant – Radiographic images of full arch or panoramic radiographic image are required for implants along with the treatment plan for replacing all missing teeth and teeth that require extraction. Date (month and year) of any prior prosthesis replacing tooth/teeth to be replaced with implant(s).

Example 3 Orthodontics – The degree and classification of malocclusion is required for orthodontics as follows:

- Classification of malocclusion (this means Class I, II, III)
- Degree of overjet, in mm
- Degree of overbite, in mm
- Degree of arch length discrepancy, maxillary, in mm
- Degree of arch length discrepancy, mandibular, in mm
- Description, if any, of cross bite
- Photographs of occlusion
- Cephalometric image or tracing, if available

By submitting this information with your claim, you may avoid claim processing delays.

Section 4 Your Cost For Covered Services

This is what you will pay out-of-pocket for covered care:

Copayment

A copayment is a fixed amount of money you pay to the provider when you receive services.

GEHA Connection Dental Federal® **High Option** – no copay.

GEHA Connection Dental Federal® **Standard Option** – no copay.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. We will base this percentage on either the billed charge or the plan allowance, whichever is less.

For High Option your coinsurance is as follows:

- Class A – nothing
- Class B – 20%
- Class C – 50%
- Class D – 30%

For Standard Option your coinsurance is as follows:

- Class A – nothing
- Class B – 45%
- Class C – 65%
- Class D – 30%

Note: If your provider routinely waives (does not require you to pay) your coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived. For example, if your dentist ordinarily charges $100 for a service but routinely waives your 50 percent coinsurance, the actual charge is $50. We will pay $25 (50 percent of the actual charge of $50).

Annual Benefit Maximum

Once you reach this amount, you are responsible for all charges. For High Option, there is an annual benefit maximum per person of $35,000 for combined Class A, Class B and Class C covered services. For Standard Option, there is an annual benefit maximum per person of $2,500 for combined Class A, Class B and Class C covered services. Once the annual benefit maximum has been met, no additional benefits will be paid for Class A, Class B or Class C covered services for that person for that calendar year.

Lifetime Benefit Maximum

The lifetime benefit maximum applies to orthodontic (Class D) covered services only. Once you reach this amount, you are responsible for all charges. This plan has a lifetime benefit maximum of $2,500 per person.

Note: The lifetime benefit maximum applies even if you do not remain continuously enrolled. Any amount applied to the lifetime benefit maximum while previously covered under this plan will apply toward your lifetime benefit maximum when you re-enroll with this plan.

And, if you change from High Option to Standard Option (or vice versa) in the plan during the year or during Open Season, we will apply the amount previously applied to the lifetime benefit maximum from your old option to the lifetime benefit maximum of your new option.

In-Network Services

In-network services are services provided by an in-network participating provider, also referred to as a PPO provider. Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use. In-network providers agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your coinsurance or any amount remaining after the annual maximum is met. Here is an example of how using a preferred provider can save you money: You see a PPO dental practitioner who charges $120 for a Class B restorative service and our maximum allowable is $100. If you have not met your annual maximum, you are only responsible for your coinsurance. That is, with High Option, you pay just 20 percent of our $100 allowance ($20). Because of the agreement, your PPO dental practitioner will not bill you for the $20 difference between our allowance and the bill.

Out-of-Network Services

Out-of-network services are services provided by a provider that does not participate in our network of providers, also referred to as non-PPO providers. Non-PPO providers have no agreement to limit what they will bill you. When you use a Non-PPO provider, you will pay your coinsurance, plus any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO dental practitioner who charges $120 and our maximum allowance is $100. Because you have not met your annual maximum, you are responsible for your coinsurance, so with High Option you pay 20 percent of our $100 allowance ($20). Plus, because there is no agreement between the non-PPO provider and us, your dental practitioner can also bill you for the $20 difference between our allowance and the bill for a total of $40.

Emergency Services

Emergency or accident related services are covered the same as any other benefit.

Plan Allowance

The plan allowance is the amount we allow for a specific procedure. When you use a participating provider, your out-of-pocket cost is limited to the difference between the plan allowance and our payment. When you use an out-of-network provider, you are responsible for the difference between our payment and the billed amount.

Private Contract

A dentist may ask you to sign a private contract agreeing to pay the billed amount for upgraded or specialty services. Should you sign an agreement, you will be responsible for the difference between the billed amount and our payment.

If We Overpay You

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments. Federal Laws supersede State Laws regarding our right to recovery of overpayments.

Subrogation

If GEHA pays benefits for an illness or injury for which you or your dependent are later compensated or reimbursed from another source, you must refund GEHA from any recovery you or your dependent obtain. All GEHA benefit payments in these circumstances are conditional, and remain subject to our contractual benefit limitations, exclusions and maximums.

Federal Laws

Federal Laws supersede State Laws including, but not limited to; coordination of benefits, subrogation, claim processing, provider filing and provider processing.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible for this plan.
- The High Option annual benefit maximum is $35,000 per covered person.
- The Standard Option annual benefit maximum is $2,500 per covered person.
- Covered services shall include only those services specifically listed in Section 5 Dental Services and Supplies. A covered service must be incurred and completed while the person receiving the service is a covered person. Covered services are subject to plan provisions for exclusions and limitations and meet acceptable standards of dental practice as determined by us.
- Covered services are limited to the maximum allowable charge as determined by us and are subject to alternative benefit, coinsurance, maximum benefit limits, waiting period and the other limitations described in this plan document.

You Pay:

- ***High Option***
  - **In-Network:** Nothing.
  - **Out-of-Network:** Any difference between the plan allowance and the billed amount.
- ***Standard Option***
  - **In-Network:** Nothing
  - **Out-of-Network:** Any difference between the plan allowance and the billed amount.

Diagnostic and treatment services
Oral evaluations (all types) are limited to a maximum of two times per Calendar Year.
D0120 Periodic oral evaluation
D0140 Limited oral evaluation – problem focused
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150 Comprehensive oral evaluation
D0180 Comprehensive periodontal evaluation
D0210 Intraoral – complete series (including bitewings) – *Full mouth radiographic images and panoramic radiographic image are limited to a combined maximum of once every Calendar Year.*
D0220 Intraoral – periapical first radiographic image
D0230 Intraoral – periapical – each additional radiographic image
D0240 Intraoral – occlusal radiographic image
D0250 Extraoral –2D projection radiographic image creating using a stationary radiation source, and detector
D0251 Extraoral – posterior dental radiographic image
D0270 Bitewing – single radiographic image – *Limited to twice per Calendar Year.*
D0272 Bitewings – two radiographic image – *Limited to twice per Calendar Year.*
D0273 Bitewings – three radiographic image – *Limited to twice per Calendar Year.*
D0274 Bitewings – four radiographic image – *Limited to twice per Calendar Year.*
D0277 Vertical bitewings – 7 to 8 radiographic image – *Limited to twice per Calendar Year.*
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Diagnostic and treatment services - continued on next page

Diagnostic and treatment services (cont.)
D0330 Panoramic radiographic image – *Full mouth radiographic images and panoramic radiographic image are limited to a combined maximum of once every Calendar Year.*
D0425 Caries susceptibility tests
Preventive services
D1110 Prophylaxis – adult – *Limited to twice per Calendar Year.*
D1120 Prophylaxis – child – *Limited to twice per Calendar Year.*
Topical application of fluoride is limited to Covered Persons under age 22 twice per Calendar Year.
D1206 Topical application of fluoride varnish
D1208 Topical application of fluoride - excluding varnish
Sealants are limited to Covered Persons under 18 years of age on unrestored permanent teeth only and are limited to one sealant per tooth every 3 Calendar Years.
D1351 Sealant – per tooth
D1352 Preventive resin restoration in a moderate to high caries risk patient – permanent tooth
D1354 Interim caries arresting medicament application
Space maintainers are limited to initial appliance, no more than one per tooth, for non-orthodontic treatment of prematurely lost teeth in children under age 19.
D1510 Space maintainer – fixed – unilateral
D1515 Space maintainer – fixed – bilateral
D1520 Space maintainer – removable – unilateral
D1525 Space maintainer – removable – bilateral
D1550 Re-cement or re-bond space maintainer - *Limited to twice per Calendar Year.*
D1575 Distal Shoe Space Maintainer - Fixed - Unilateral
Additional procedures covered as basic services
D9110 Palliative treatment of dental pain – minor procedure
D9310 Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)
D9440 Office visit after regularly scheduled hours
Not covered:
• *Plaque control programs*
• *Oral hygiene instruction*
• *Dietary instructions*
• *Over-the-counter dental products, such as teeth whiteners, toothpaste, dental floss*
• *Any exclusions or limitations listed under Section 7 of this plan document*
• *Charges for missed appointments*
• *Filling out paperwork*
• *Submitting claim forms*
• *Sterilizing instruments*
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Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible for this plan.
- The High Option annual benefit maximum is $35,000 per covered person.
- The Standard Option annual benefit maximum is $2,500 per covered person.
- Covered services shall include only those services specifically listed in Section 5, Dental Services and Supplies. A covered service must be incurred and completed while the person receiving the service is a covered person. Covered services are subject to plan provisions for exclusions and limitations and meet acceptable standards of dental practice as determined by us.
- For services listed with an asterisk (*), the choice of a lower cost treatment is available. If you or your dental provider should choose this treatment or service, we will allow the lower cost alternative benefit unless evidence is submitted with the bill to explain why the less expensive treatment could not be done.
- Covered services are limited to the maximum allowable charge as determined by us and are subject to alternative benefit, coinsurance, maximum benefit limits, waiting period and the other limitations described in this document.
- The dental plan does not require a pre-treatment estimate of benefits. GEHA will respond to a request to pre-determine services with an estimate of covered service, which is not a guarantee of payment since future changes such as changes in your enrollment or eligibility under the dental plan may affect benefits. We encourage you to ask your provider to request a pre-treatment estimate for any extensive treatment. By obtaining a pre-treatment estimate, you and your dental provider will have an estimate before treatment begins of what will be covered and how it will be paid. This information can be valuable to you in making an informed decision on how to proceed with treatment and can help protect you from unexpected out-of-pocket costs should the treatment plan not be covered.
- To obtain a pre-determination, the dentist should submit a completed dental pre-treatment estimate claim form that itemizes the proposed procedure codes, charge for each procedure along with pre-treatment plan, radiographic images and any other diagnostic materials.

You Pay:

- ***High Option***
  - **In-Network:** 20% of plan allowance.
  - **Out-of-Network:** 20% of the plan allowance and any difference between our allowance and the billed amount.
- ***Standard Option***
  - **In-Network:** 45% of plan allowance.
  - **Out-of-Network:** 45% of the plan allowance and any difference between our allowance and the billed amount.

Minor restorative services
Fillings are limited to one restoration per tooth surface every 2 Calendar Years.
D2140 Amalgam – one surface, primary or permanent
D2150 Amalgam – two surfaces, primary or permanent
D2160 Amalgam – three surfaces, primary or permanent
D2161 Amalgam – four or more surfaces, primary or permanent
D2330 Resin-based composite – one surface, anterior
D2331 Resin-based composite – two surfaces, anterior
D2332 Resin-based composite – three surfaces, anterior
D2335 Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2391 Resin-based composite – one surface, posterior
D2392 Resin-based composite – two surfaces, posterior
D2393 Resin-based composite – three surfaces, posterior
D2394 Resin-based composite – four or more surfaces, posterior
*D2610 Inlay – porcelain/ceramic, one surface
*D2620 Inlay – porcelain/ceramic, two surfaces
*D2630 Inlay – porcelain/ceramic, three or more surfaces
D2910 Re-cement or re-bond inlay, veneer – *Limited to once per 6 month period if more than 12-months from initial placement*
D2920 Re-cement or re-bond crown – *Limited to once per 6 month period if more than 12-months from initial placement*
D2930 Prefabricated stainless steel crown – primary tooth – *Limited to one per patient, per tooth, per lifetime for Covered Persons under 15 years of age*
D2931 Prefabricated stainless steel crown – permanent tooth – *Limited to one per patient, per tooth, per lifetime for Covered Persons under 15 years of age*
D2951 Pin retention – per tooth, in addition to restoration
Not covered: • *Restorations, including veneers, which are placed for cosmetic purposes only* • *Gold foil restorations* • *Any exclusions or limitations listed under Section 7 of this plan document*
Endodontic services
D3110 Pulp cap – direct (excluding final restoration) - *Charges that are submitted without a report will be denied as non-covered benefits.*
D3120 Pulp cap – indirect (excluding final restoration) - *Charges that are submitted without a report will be denied as non-covered benefits.*
D3220 Therapeutic pulpotomy (excluding final restoration) –*Therapeutic pulpotomy is limited to once per primary tooth per lifetime.*
D3221 Pulpal debridement, primary and permanent teeth
D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development.
D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) – *Limited to primary incisor teeth for children up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.*
D3240 Pulpal therapy (resorbable filling) – posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. – *Limited to primary incisor teeth for children up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.*
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Periodontal services
Periodontal scaling and root planing are limited to once per quadrant every 2 Calendar Years and are not covered if done within 24 months of periodontal surgical procedures in the same quadrant.
D4341 Periodontal scaling and root planing – four or more teeth per quadrant
D4342 Periodontal scaling and root planing – one to three teeth, per quadrant
D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *Limited to a maximum of once every 2 Calendar Years and not covered if done within 24 months of periodontal scaling and root planing.*
D4910 Periodontal maintenance –*Periodontal maintenance is only covered when performed following active periodontal treatment. Routine prophylaxis and periodontal maintenance are limited to a combined total of four per Calendar Year.*
D7921 Collection and application of autologous blood concentrate product
Prosthodontic services
Adjustment or repair to denture or partial denture are limited to two per Calendar Year, at least 6 months after delivery of appliance.
D5410 Adjust complete denture – maxillary
D5411 Adjust complete denture – mandibular
D5421 Adjust partial denture – maxillary
D5422 Adjust partial denture – mandibular
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth – complete denture (each tooth)
D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp - per tooth
D5640 Replace broken teeth – per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture - per tooth
Replacement of all teeth and acrylic on cast metal framework is limited to once every five Calendar Years.
D5670 Replace all teeth and acrylic on cast metal framework, maxillary
D5671 Replace all teeth and acrylic on cast metal framework, mandibular
Rebase and reline of dentures is limited to a maximum of once every 3 Calendar Years after 6 months of initial placement.
D5710 Rebase complete maxillary denture
D5711 Rebase complete mandibular denture
D5720 Rebase maxillary partial denture
D5721 Rebase mandibular partial denture
D5730 Reline complete maxillary denture (chairside)
D5731 Reline complete mandibular denture (chairside)
D5740 Reline maxillary partial denture (chairside)
D5741 Reline mandibular partial denture (chairside)
D5750 Reline complete maxillary denture (laboratory)
D5751 Reline complete mandibular denture (laboratory)
D5760 Reline maxillary partial denture (laboratory)
D5761 Reline mandibular partial denture (laboratory) Rebase/Reline
D5850 Tissue conditioning (maxillary) – *Not covered if done the same day as delivery of dentures, reline or rebase.*
D5851 Tissue conditioning (mandibular) – *Not covered if done the same day as delivery of dentures, reline or rebase.*
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Prosthodontic services - continued on next page

Prosthodontic services (cont.)
D6930 Re-cement or re-bond fixed partial denture – *Recement of crowns, fixed partial denture or onlays is limited to one per Calendar Year, after 6 months of initial placement.*
D6980 Fixed partial denture repair, by report – *Coverage determined by report. Charges submitted without report are not covered.*
Oral surgery
D7111 Extraction coronal remnants, deciduous tooth
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
*D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
Removal of impacted tooth – Removal of impacted third molars in Covered Persons is not covered unless specific documentation is provided that substantiates the need for removal and is approved by us.
D7220 Removal of impacted tooth – soft tissue
D7230 Removal of impacted tooth – partially bony
D7240 Removal of impacted tooth – completely bony
*D7241 Removal of impacted tooth – completely bony, with unusual surgical complications
D7250 Removal of residual tooth roots (cutting procedure)
D7251 Coronectomy – intentional partial tooth removal
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Exposure of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions – per quadrant
D7311 Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions – per quadrant
D7321 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess – intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7971 Excision of pericoronal gingiva
*D7999 Unspecified oral surgery procedure, by report. *Charges submitted without report are not covered. The plan allowance will be determined upon review of the report.*
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Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible for this plan.
- The High Option annual benefit maximum is $35,000 per covered person.
- The Standard Option annual benefit maximum is $2,500 per covered person.
- Implant services are limited to an annual maximum of $2,500 per covered person included in the annual benefit maximum.
- Covered services shall include only those services specifically listed in Section 5 Dental Services and Supplies. A covered service must be incurred and completed while the person receiving the service is a covered person. Covered services are subject to plan provisions for exclusions and limitations and meet acceptable standards of dental practice as determined by us.
- For services listed with an asterisk (*), the choice of a lower cost treatment is available. If you or your dental practitioner should choose this treatment or service, we will allow the lower cost alternative benefit unless evidence is submitted with the bill to explain why the less expensive treatment could not be done.
- Covered services are limited to the maximum allowable charge as determined by us and are subject to alternative benefit, coinsurance, maximum benefit limits, waiting period and the other limitations described in this plan document.
- The dental plan does not require a pre-treatment estimate of benefits. GEHA will respond to a request to pre-determine services with an estimate of covered service, which is not a guarantee of payment since future changes such as changes in your enrollment or eligibility under the dental plan may affect benefits. We encourage you to ask your provider to request a pre-treatment estimate for any extensive treatment. By obtaining a pre-treatment estimate, you and your dental provider will have an estimate before treatment begins of what will be covered and how it will be paid. This information can be valuable to you in making an informed decision on how to proceed with treatment and can help protect you from unexpected out-of-pocket costs should the treatment plan not be covered.
- To obtain a pre-determination, the dentist should submit a completed dental pre-treatment estimate claim form that itemizes the proposed procedure codes, charge for each procedure along with pre-treatment plan, radiographic images and any other diagnostic materials.

You Pay:

- ***High Option***
  - **In-Network:** 50% of plan allowance.
  - **Out-of-Network:** 50% of plan allowance and any difference between our allowance and the billed amount.
- ***Standard Option***
  - **In-Network:** 65% of plan allowance.
  - **Out-of-Network:** 65% of plan allowance and any difference between our allowance and the billed amount.

Major restorative services
D0160 Detailed and extensive oral evaluation – problem focused, by report – *Detailed and extensive oral evaluations are limited to once per covered person per dentist, per lifetime.*
Replacement crowns, inlays, onlays, buildups and posts and cores are covered only 5 years after initial or replacement unless required as a result of an accidental bodily injury and satisfactory evidence is presented showing the crown, inlay, onlay, buildup or post and core cannot be made serviceable.
Crowns, inlays, onlays and posts and cores are payable only when required for restorative purposes and necessary due to decay or tooth fracture and evidence is presented showing the tooth cannot be adequately restored with an amalgam or composite filling.
*D2510 Inlay – metallic – one surface
*D2520 Inlay – metallic – two surface
*D2530 Inlay – metallic – three surface
D2542 Onlay – metallic – two surfaces
D2543 Onlay – metallic – three surfaces
D2544 Onlay – metallic – four or more surfaces
*D2642 Onlay – porcelain/ceramic, two surfaces
*D2643 Onlay – porcelain/ceramic, three surfaces
*D2644 Onlay – porcelain/ceramic, four or more surfaces
*D2662 Onlay – resin based composite, two surfaces
*D2663 Onlay – resin based composite, three surfaces
*D2664 Onlay – resin based composite, four or more surfaces
*D2710 Crown – resin based composite (indirect)
*D2712 Crown – 3/4 resin based composite (indirect)
*D2720 Crown – resin with high noble metal
*D2721 Crown – resin with predominantly base metal
*D2722 Crown – resin with noble metal
*D2740 Crown – porcelain/ceramic substrate
*D2750 Crown – porcelain fused to high noble metal
D2751 Crown – porcelain fused to predominately base metal
*D2752 Crown – porcelain fused to noble metal
*D2780 Crown – 3/4 cast high noble metal
D2781 Crown – 3/4 cast predominately base metal
*D2782 Crown – 3/4 cast noble metal
*D2783 Crown – 3/4 porcelain/ceramic - *for posterior teeth only*
*D2790 Crown – full cast high noble metal
D2791 Crown – full cast predominately base metal
*D2792 Crown – full cast noble metal
*D2794 Crown – titanium
D2950 Core buildup, including any pins – *Core buildups are covered only when there is evidence presented showing insufficient retention for a crown.*
Posts are only covered when provided as part of a buildup for a crown. When performed as an independent procedure, the placement of a post is not covered.
*D2952 Cast post and core in addition to crown
*D2953 Each additional cast post – same tooth
D2954 Prefabricated post and core, in addition to crown
*D2957 Each additional prefabricated post – same tooth
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Major restorative services - continued on next page

Major restorative services (cont.)
D2980 Crown repair, by report – *Coverage determined by report. Charges submitted without reports are not covered.*
D2981 Inlay repair necessitated by restorative material failure, *by report*
D2982 Onlay repair, *by report*
D2983 Veneer repair necessitated by restorative material failure, *by report*
D2990 Resin infiltration of incipient smooth surface lesions
Not covered: • *Gold foil restorations* • *Protective restoration* • *Restorations for cosmetic purposes only* • *Composite resin inlays* • *Any exclusions or limitations listed under Section 7 of this plan document*
Endodontic services
D3310 Anterior root canal (excluding final restoration)
D3320 Bicuspid root canal (excluding final restoration)
D3330 Molar root canal (excluding final restoration)
Retreatment of root canal is covered only after 12 months from the prior root canal therapy.
D3346 Retreatment of previous root canal therapy – anterior
D3347 Retreatment of previous root canal therapy – bicuspid
D3348 Retreatment of previous root canal therapy – molar
D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353 Apexification/recalcification – final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
D3355 Pulpal regeneration – initial visit
D3356 Pulpal regeneration – interim medication replacement
D3357 Pulpal regeneration – completion of treatment
D3410 Apicoectomy surgery – anterior
D3421 Apicoectomy surgery – bicuspid (first root)
D3425 Apicoectomy surgery – molar (first root)
D3426 Apicoectomy surgery (each additional root)
D3427 Periradicular surgery without apicoectomy
D3430 Retrograde filling – per root
D3450 Root amputation – per root
D3920 Hemisection (including any root removal) – not including root canal therapy
Periodontal services
Gingivectomy, gingivoplasty, gingival flap procedure, and osseous surgery are limited to once per quadrant every 2 Calendar Years.
D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces, per quadrant
D4211 Gingivectomy or gingivoplasty – one to three teeth, per quadrant
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4240 Gingival flap procedure, including root planing, four or more contiguous teeth or bounded teeth spaces per quadrant
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Periodontal services - continued on next page

Periodontal services (cont.)
D4241 Gingival flap procedure, including root planing – one to three teeth contiguous teeth or tooth bounded spaces per quadrant
D4249 Clinical crown lengthening – hard tissue
D4260 Osseous surgery (including elevation of a full thickness flap and closure), four or more contiguous teeth or tooth bounded spaces per quadrant
D4261 Osseous surgery (including elevation of a full thickness flap and closure), one to three contiguous teeth or tooth bounded spaces per quadrant
D4268 Surgical revision procedure, per tooth
Tissue graft procedures are not covered when treating implants or in edentulous areas.
D4270 Pedicle soft tissue graft procedure - *Tissue graft procedures are not covered when treating implants or in edentulous areas.*
D4273 Autogenous connective tissue graft procedures (including donor and recipient surgical sites), first tooth - *Tissue graft procedures are not covered when treating implants or in edentulous areas.*
D4275 Non-autogenous connective tissue graft (including recipient site and donor material), first tooth -*Tissue graft procedures are not covered when treating implants or in edentulous areas.*
D4276 Combined connective tissue and double pedicle graft, per tooth
D4277 Free soft tissue graft procedure, (including recipient and donor surgical sites), first tooth - *Tissue graft procedures are not covered when treating implants or in edentulous areas.*
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth - *Tissue graft procedures are not covered when treating implants or in edentulous areas.*
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis – *Limited to once per lifetime.*
D4381 Localized delivery of antimicrobial agents - Coverage determined by review of report. Service is only covered for residual periodontal disease with inflammation and the service is necessary to treat specific sites that are unresponsive to prior active periodontal treatment. Charges submitted without report are not covered.
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites), each additional contiguous tooth - *Tissue graft procedures are not covered when treating implants or in edentulous areas.*
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth - *Tissue graft procedures are not covered when treating implants or in edentulous areas.*
Prosthodontic services
The replacement of an existing prosthodontic device will be considered a covered service only if at least one of the following conditions is met: • *The replacement appliance replaces an existing appliance that is at least 5 years old and cannot be made serviceable.* • *The replacement appliance is required as the result of accidental bodily injury that occurs after the date the person became a covered person and the appliance cannot be made serviceable.*
D5110 Complete denture – maxillary
D5120 Complete denture – mandibular
D5130 Immediate denture – maxillary
D5140 Immediate denture – mandibular
D5211 Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5212 Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5213 Maxillary partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5214 Mandibular partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5221 Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5222 Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
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Prosthodontic services - continued on next page

Prosthodontic services (cont.)
D5223 Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5281 Removable unilateral partial denture – one piece cast metal (including clasps and teeth)
*D6210 Pontic – cast high noble metal
*D6211 Pontic – cast predominately base metal
*D6212 Pontic – cast noble metal
*D6214 Pontic – titanium
*D6240 Pontic – porcelain fused to high noble metal
*D6241 Pontic – porcelain fused to predominately base metal
*D6242 Pontic – porcelain fused to noble metal
*D6245 Pontic – porcelain/ceramic
*D6545 Retainer – cast metal for resin bonded fixed prosthesis
*D6548 Retainer – porcelain/ceramic for resin bonded fixed prosthesis
*D6549 Resin retainer – for resin bonded fixed prosthesis
*D6601 Retainer inlay – porcelain/ceramic, three or more surfaces
*D6604 Retainer Inlay – cast predominantly base metal, two surfaces
*D6605 Retainer Inlay – cast predominantly base metal, three or more surfaces
*D6740 Retainer Crown – porcelain/ceramic
*D6750 Retainer Crown – porcelain fused to high noble metal
*D6751 Retainer Crown – porcelain fused to predominately base metal
*D6752 Retainer Crown – porcelain fused to noble metal
*D6780 Retainer Crown – 3/4 cast high noble metal
*D6781 Retainer Crown – 3/4 cast predominately base metal
*D6782 Retainer Crown – 3/4 cast noble metal
*D6783 Retainer Crown – 3/4 porcelain/ceramic
*D6790 Retainer Crown – full cast high noble metal
*D6791 Retainer Crown – full cast predominately base metal
*D6792 Retainer Crown – full cast noble metal
*D6794 Retainer Crown – Titanium
Implant services
Implant Services – The following implant procedure codes may be allowed under the implant benefit. We will limit payment on covered implant(s) - including abutment, implant, crown, implant-supported appliances such as partial denture (bridge), pontic, full denture and other implant procedures to a calendar year maximum of $2,500. Replacement implant services are covered only 5 years after initial placement unless required as a result of an accidental bodily injury and satisfactory evidence is presented showing the implant services could not be made serviceable.
D6010 Surgical placement of implant body: endosteal implant
D6055 Connecting bar - implant supported or abutment supported
D6056 Prefabricated abutment – includes modification and placement
D6057 Custom abutment – includes modification and placement
D6058 Abutment supported porcelain/ceramic crown
D6059 Abutment supported porcelain fused to metal crown (high noble metal)
D6060 Abutment supported porcelain fused to metal crown (predominantly based metal)
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Implant services - continued on next page

Implant services (cont.)
D6061 Abutment supported porcelain fused to metal crown (noble metal)
D6062 Abutment supported cast metal crown (high noble metal)
D6063 Abutment supported cast metal crown (predominantly based metal)
D6064 Abutment supported cast metal crown (noble metal)
D6065 Implant supported porcelain/ceramic crown
D6066 Implant supported porcelain fused to metal crown (titanium, titanium allow, high noble metal)
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal)
D6068 Abutment supported retainer for porcelain/ceramic FPD
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072 Abutment supported retainer for cast metal FPD (high noble metal)
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074 Abutment supported retainer for cast metal FPD (noble metal)
D6075 Implant supported retainer for ceramic FPD
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
D6080 Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis
D6081 Scaling and debridement in the presence of inflammation of mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure - *Limited to a maximum of once every 2 Calendar Years and not covered if done within 24 months of periodontal scaling and root planing*
D6090 Repair implant supported prosthesis, by report
D6091 Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6094 Abutment supported crown (titanium)
D6095 Repair implant abutment, by report
D6100 Implant removal, by report
D6110 Implant/abutment supported removable denture for edentulous arch-maxillary
D6111 Implant/abutment supported removable denture for edentulous arch-mandibular
D6112 Implant/abutment supported removable denture for partially edentulous arch-maxillary
D6113 Implant/abutment supported removable denture for partially edentulous arch-mandibular
D6114 Implant/abutment supported fixed denture for edentulous arch-maxillary
D6115 Implant/abutment supported fixed denture for edentulous arch-mandibular
D6116 Implant/abutment supported fixed denture for partially edentulous arch maxillary
D6117 Implant/abutment supported fixed denture for partially edentulous arch-mandibular
D6194 Abutment supported retainer crown for FPD - (titanium)
Not covered: • *Any implant placement or removal, appliance placed on, or services associated with implants not specifically listed above.* • *Any implant services or treatment provided primarily for cosmetic purposes.*
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Adjunctive general services
Sedation/Anesthesia - Deep sedation/general anesthesia and intravenous conscious sedation are covered only when provided in connection with a covered procedure(s) and when determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions. To be covered, the procedure for which deep sedation/general anesthesia and intravenous conscious sedation was provided must be submitted along with a report of why anesthesia was necessary. Charges submitted without a report will be denied as non-covered benefits.
D9223 Deep sedation/general anesthesia – each 15 minute increment
D9243 Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
D9610 Therapeutic drug injection, by report – *Therapeutic drug injections are not covered if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication. Charges submitted without a report will be denied as non-covered benefits.*
D9612 – Therapeutic parenteral drugs, two or more administrations, different medications – *Therapeutic drug injections are not covered if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication. Charges submitted without a report will be denied as non-covered benefits.*
D9930 Treatment of complications (post-surgical) unusual circumstances, by report – *Coverage determined by review of report. Charges submitted without report are not covered.*
D9940 Occlusal guard, by report – *Occlusal guards are limited to once per Calendar Year for covered persons age 13 or older and treatment is for bruxism or to protect the teeth from grinding, chipping or fracture. An occlusal guard for temporomandibular joint dysfunction or other non dental related treatment is not covered. Charges submitted without a report will be denied as non-covered benefits.*
D9941 Fabrication of athletic mouthguard – *Limited to once per covered person per Calendar Year.*
D9974 Internal bleaching – per tooth – *Internal bleaching of discolored teeth is covered for endodontically treated anterior teeth once per covered person per tooth every 3 calendar years. External bleaching of discolored teeth is not a covered benefit.*
*D9999 Unspecified adjunctive procedure, by report. Charges submitted without report are not covered. *The plan allowance will be determined upon review of the report.*
Not covered: • *Precision attachments, personalization, precious metal bases, and other specialized techniques* • *Replacement of dentures that have been lost, stolen or misplaced* • *Removable or fixed prostheses initiated prior to the effective date of coverage or inserted/cemented after the coverage ending date* • *Any exclusions or limitations listed under Section 7 of this plan document*
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Class D Orthodontic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible for this plan.
- There is a lifetime maximum benefit of $2,500 under the High Option and Standard Option for Class D covered services.
- There is a 12-month waiting period for Class D benefits on the Standard Option plan. To meet this requirement, the covered person must be continuously enrolled under this dental plan for the entire waiting period.
- There is no waiting periods for Class D benefits on the High Option plan.
- Covered services shall include only those services specifically listed in Section 5, Dental Services and Supplies. A covered service must be incurred and completed while the person receiving the service is a covered person. Covered services are subject to plan provisions for exclusions and limitations and meet acceptable standards of dental practice as determined by us.
- Covered services are limited to the maximum allowable charge as determined by us and are subject to alternative benefit, coinsurance, maximum benefit limits, waiting period and the other limitations described in this plan document.
- The dental plan does not require a pre-treatment estimate of benefits. GEHA will respond to a request to pre-determine services with an estimate of covered service, which is not a guarantee of payment since future changes such as changes in your enrollment or eligibility under the dental plan may affect benefits. We encourage you to ask your provider to request a pre-treatment estimate for any extensive treatment. By obtaining a pre-treatment estimate, you and your dental provider will have an estimate before treatment begins of what will be covered and how it will be paid. This information can be valuable to you in making an informed decision on how to proceed with treatment and can help protect you from unexpected out-of-pocket costs should the treatment plan not be covered.
- To obtain a pre-determination, the dentist should submit a completed dental pre-treatment estimate claim form that itemizes the proposed procedure codes, charge for each procedure along with pre-treatment plan, radiographic images and any other diagnostic materials.

You Pay:

- ***High Option***
  - **In-Network:** 30% of plan allowance.
  - **Out-of-Network:** 30% of plan allowance and any difference between our allowance and the billed amount.
- ***Standard Option***
  - **In-Network:** 30% of plan allowance.
  - **Out-of-Network:** 30% of plan allowance and any difference between our allowance and the billed amount.

Orthodontic services
Initial payment for orthodontic treatment will not be made until the appliance placement date has been submitted to us.
Orthodontic treatment is not covered if the initial placement of the appliance on the teeth was made prior to the person becoming covered.
Charges will be considered, subject to other plan conditions, as follows: • *The total case fee and the maximum allowed amount will be divided by the number of months for the total treatment plan. Each resulting portion will be considered to be incurred on a quarterly basis until the lifetime maximum is paid, treatment is completed or eligibility ends, whichever comes first.* *For example: When a provider bills $3,600 for a 24-month treatment plan including miscellaneous services, we will divide our allowable by 24 months ($3,600 divided by 24 months equals $150 per month). Our quarterly allowable will be $150 times 3 months or $450. Our allowable is reimbursed at 70% for a quarterly payment of $315. As the treatment plan is 24 months and we pay quarterly, we will process 8 quarterly payments, 7 payments at $315 and the last payment at $295, which equals $2,500 (your lifetime maximum). You will owe the difference between the billed amount and our payment ($3,600 less $2,500 equals $1,100).* • *Verification that the covered person is still receiving active treatment is required from the provider once every 3 months.*
D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of adult dentition
D8050 Interceptive orthodontic treatment of the primary dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition
D8210 Removable appliance therapy
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment examination to monitor growth and development
D8670 Periodic orthodontic treatment visit – *When part of the contract, a periodic orthodontic treatment visit is considered part of complete orthodontic treatment plan and not reimbursable as a separate service.*
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)
D8690 Orthodontic treatment (alternative billing to a contract fee) – *Orthodontic treatment (alternative billing to a contract fee) will be reviewed for individual consideration and is only considered when services are rendered by a dentist other than the dentist rendering complete orthodontic treatment.*
Not covered: • *Repair of damaged orthodontic appliances* • *Replacement of lost or missing appliance* • *Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.* • *Any exclusions or limitations listed under Section 7 of this plan document*
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Section 6 International Services and Supplies

International Claims Payment

International services are services provided outside of the United States. The dental plan provides care even when a member is outside of the United States. Benefits and contract limits are the same for services received outside of the United States as for services received stateside.

To obtain emergency care while outside of the United States, you should see a covered provider and submit the bill for reimbursement. This plan lets you choose your own dental practitioner. This plan reimburses you or your provider for covered services. We do not typically provide or arrange for dental care.

Finding an International Provider

GEHA's in-network providers extend to the United States and US Territories (Puerto Rico, Guam and the U.S. Virgin Islands). In-network providers do not extend outside of the United States other than the areas listed. You have the right to choose any licensed dental practitioner; you do not need to contact GEHA first.

Note: Because international claims do not have the consideration of stateside cost containment, members must be cautious to guard against inappropriate/excessive services.

GEHA has a dedicated email address for our members outside the United States, overseas.gehadental@geha.com.

Filing International Claims

For services you receive outside of the United States, send itemized bills that include an English translation and the exchange rate on the date the services were rendered. We will use the daily rate of exchange for the date of service. Eligible benefits are paid in United States currency. All international claims should be submitted to GEHA, Foreign Dental Claims Department, P. O. Box 2336, Independence, MO 64051-2336.

Customer Service Website and Phone Numbers

Go to our website at www.gehadental.com or contact our Customer Service Department toll-free at (877) 434-2336 or TDD (800) 821-4833.

International Rates

There is one international region. Please see rate table for the actual premium amount.

Section 7 General Exclusions – Things We Do Not Cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care, or treatment of a covered condition.**

We do not cover the following:

- Any dental service or treatment not specifically listed as a covered service.
- Missed or canceled appointments, telephone consultations, completion of claim form required by us or forwarding records requested by us.
- Dentures that have been lost, stolen or misplaced.
- Duplicate and temporary dentures, appliances, devices, radiographic images and services.
- Experimental services or treatment not generally recognized by the dental profession as necessary for treatment of the condition or for which there is no reasonable expectation of effective treatment.
- Services or treatment provided for oral hygiene instruction or dietary counseling for the control of dental caries and plaque.
- Services or treatment provided by or paid for by any government or government employed dental practitioner, unless the covered person is legally required to pay for such services or supplies.
- Services or treatment for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the law or regulation of any governmental unit. This exclusion applies whether or not you claim the benefit or compensation.
- Services or treatment of congenital malformations.
- Repair or replacement of orthodontic appliances.
- Services or treatment provided primarily for cosmetic purposes.
- Service or supplies furnished by yourself, household members or immediate relatives, such as spouse, parents, children, brothers or sisters, by blood, marriage, or adoption.
- Any treatment not prescribed or performed by a licensed physician or dental practitioner.
- Services or treatment for which no charge (or the patient has no responsibility to pay) would be made in absence of this coverage including, but not limited to, discounts, disallow due to negotiated rate and provider write-off amounts.
- Services or treatment resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization.
- Services or treatment provided as a result of intentionally self-inflicted injury or illness.
- Services or treatment provided as a result of injuries suffered while:
  - Committing or attempting to commit a felony;
  - Engaging in an illegal occupation; or
  - Participation in a riot, rebellion or insurrection.
- Office infection control.
- Any implant placement or removal, appliances placed on, or services associated with implants not specifically listed in Section 5, Class C, Implant services, including but not limited to; anesthesia and IV sedation, ridge augmentation and grafting procedures.
- Any procedure, appliance or restoration that alters the bite and/or restores or maintains the bite. Bite means the way teeth meet or occlusion and vertical dimension. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restorations for malalignment of teeth. This exclusion does not apply to Class D covered services.
- Services or treatment started or performed before the effective date of coverage.

- Services rendered after the termination of coverage.
- Diagnosis and/or treatment of jaw joint problems, including temporomandibular joint (TMJ) syndrome, craniomandibular disorders, or other conditions of the joint linking the jawbone and skull or the complex of muscles, nerves and other tissue related to that joint.
- General anesthesia provided in connection with services that are not covered.
- Nitrous oxide.
- Oral sedation.
- Precision dentures, characterization or personalization of crowns, dentures or fillings.
- Gold foil restorations.
- Services or treatments that are necessary due to patient failure to follow the dental practitioner's instructions.
- Services or treatments that are not the least costly alternative that accomplishes a result that meets accepted standards of professional dental care as determined by us.
- Any service or treatment that is part of the complete dental procedure is considered a component of, and is included in, the fee for the complete procedure.
- Services received from a dental or medical department maintained by or on behalf of any employer, mutual benefit association, labor union, trust or similar person or group.
- Services performed by a dentist who is compensated by a facility for similar covered services performed for members.
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
- Service or care required as a result of complications from a treatment or service not covered under the dental plan.
- Fraudulent claims for service.
- Claims submitted later than December 31 of the calendar year following the one in which the expense was incurred, except when the member was legally incapable.
- State or territorial taxes on dental services performed.
- Adjunctive dental services as defined by applicable Federal regulations. The Federal dental program does not cover adjunctive dental care services. These are medical services that are covered by other medical insurance even when provided by a general dentist or oral surgeon. The following diagnoses or conditions may fall under this category:
  - Treatment for relief of myofacial pain dysfunction syndrome or temporomandibular joint dysfunction (TMJD).
  - Orthodontic treatment for cleft lip or cleft palate, or when required in preparation for, or as a result of, trauma to teeth and supporting structures caused by medically necessary treatment of an injury or disease.
  - Procedures associated with preventative and restorative dental care when associated with radiation therapy to the head or neck unless otherwise covered as a routine preventative procedure under this plan.
  - Total or complete ankyloglossia.
  - Intraoral abscesses that extend beyond the dental alveolus.
  - Extraoral abscesses.
  - Cellulitis and osteitis, which is clearly exacerbating and directly affecting a medical condition currently under treatment.
- Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.
- Prosthetic replacement of either the maxilla or mandible due to reduction of body tissues associated with traumatic injury (such as a gun shot wound) in addition to services related to treating neoplasms or iatrogenic dental trauma.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

No special claim forms are required. Just send in the itemized bill from your provider. In most cases, providers will file claims for you.

For in-network provider claims, it is not necessary for members to file a claim. The provider has agreed to do that for you.

For out-of-network provider claims, if you are a GEHA FEHB medical plan member, send dental claims to:

GEHA Connection Dental Federal
P.O. Box 2336
Independence, MO 64051-2336

If you are not a GEHA FEHB medical plan member, you must first submit your dental claim to your FEHB medical plan, and then submit your dental claim to GEHA, along with the FEHB medical plan's explanation of benefits (EOB). If the EOB from your FEHB medical plan is not submitted, we may estimate the amount they would have paid.

If you have other additional dental coverage, you must first submit your dental claim to your other dental plan(s), then submit your dental claim to GEHA, along with the other plan's explanation of benefits (EOB).

To control administrative costs, we will not issue benefit checks that do not exceed $1.

For claim filing assistance, call us toll-free at (877) 434-2336, or TDD (800) 821-4833.

When you must file a claim – such as for services you receive overseas or when another group health plan is primary – submit it on the ADA dental claim form or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Name of patient and relationship to member;
- Member identification number;
- Name, degree, address and signature of the provider;
- Dates that services or treatment were received;
- Description of each service or treatment in English;
- Tooth number(s) and tooth surface(s) when applicable;
- Current Dental Terminology (CDT) procedure codes when applicable; and
- Charge for each service or treatment.

We have the right to request additional information. Canceled checks, cash register receipts or balance due statements are not acceptable substitutes for itemized bills.

Keep a separate record of the dental expenses of each covered person, as maximum benefit limits apply separately to each covered person. Save copies of all dental bills. In most instances, they will serve as evidence of your claim. We will not provide duplicate or year-end statements. For duplicate explanation of benefits (EOBs), you may visit our website at www.gehadental.com. After creating a web account, you may view up to 18 months of your claim history.

Benefits may be assigned to a third party. Any assignment will be effective on the date it is assigned, subject to any actions we may take prior to our receipt of the assignment. We assume no responsibility for the validity of an assignment. We have the right to pay the member or dental practitioner at our option, whether or not we receive an assignment of benefits.

If any benefits become payable to anyone who, in our opinion, is legally incapable of giving us a valid receipt or release, we may pay a portion of such benefits to any individual or institution we believe has assumed custody or principal support for such person, provided we have not received a request for payment from the person's legal guardian or other legally appointed representative.

International Claims

For services you receive outside of the United States, send itemized bills that include an English translation and the exchange rate on the date the services were rendered. Benefits will be calculated using the daily rate of exchange for the date of service and reimbursed in United States currency. All international claims should be submitted to GEHA, Foreign Dental Claims Department, P. O. Box 2336, Independence, MO 64051-2336.

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond. See Section 6 International Services and Supplies for more information.

Deadline for Filing Your Claim

Send us all of the documents for your claims as soon as possible. You must submit the claim by December 31 of the year after the year you receive the service, unless timely filing was prevented by administrative operations of the Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a two-year limitation on the reissuance of uncashed checks.

We may, at our option, require supporting documentation such as clinical reports, charts, radiographic images, and study models.

Disputed Claims Process

Follow this disputed claims process if you disagree with our decision on your claim or request for services. **The FEDVIP law does not provide a role for OPM to review disputed claims.**

Disputed Claim Steps:

1. Ask us in writing to reconsider our initial decision. You must:

- Write to us within 6 months from the date of our decision; and
- Send your request to us at: GEHA Connection Dental Federal, P. O. Box 455, Independence, MO 64051-0455; and
- Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
- Include copies of documents that support your claim, such as dentist's letters, provider narratives, radiographic images or other records, and explanation of benefits (EOB) forms.

2. We have 30 days from the date we received your request to:

- Pay the claim (or, if applicable, arrange for the dental care provider to give you the care); or
- Write to you and maintain our denial – go to step 3; or
- Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. If you do not agree with our final decision, you may request an independent third party, mutually agreed upon by us and OPM, to review the decision. The decision of the independent third party is binding for us and is the final administrative review of your claim. To request an independent third-party review you must:

- Write to us within 90 days of our letter maintaining denial; and
- Send your request to us at: GEHA Connection Dental Federal, P. O. Box 455, Independence, MO 64051-0455; and
- Include a statement about why you are requesting an independent third-party review. This statement should include why you believe our decision to deny your claim was wrong, based on specific benefit provisions in this brochure; and include copies of documents that support your claim, such as dentist's letters, provider narratives, X-rays or other records, and explanation of benefits (EOB) forms.

4. The independent third party will review your disputed claim request and will use the information sent by you, your provider and us to decide whether our decision is correct. You will receive a copy of the third party's final decision within 60 days. The decision of the independent third party is binding and is the final review of your claim. This decision is not subject to judicial review.

Section 9 Definitions of Terms We Use in This Brochure

Accidental Bodily Injury Accidental bodily injury is an injury caused by an external force or element, such as a blow or fall requiring immediate attention. Accidental bodily injury will not include any injuries sustained as a result of a chewing incident, regardless of the condition of the tooth or teeth at the time of the chewing incident.

Adjunctive Dental Care Dental care that is:

- Medically necessary in the treatment of an otherwise covered medical (not dental) condition.
- An integral part of the treatment of such medical condition.
- Essential to the control of the primary medical condition.
- Required in preparation for or as the result of dental trauma, which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).

Annual Benefit Maximum The maximum annual benefit that you can receive per person each calendar year.

Annuitants Federal retirees (who retired on an immediate annuity) and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.

BENEFEDS The enrollment and premium administration system for FEDVIP.

Benefits Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.

Calendar Year The period of time that begins January 1 and ends December 31 of each year. For any covered person who first becomes covered after January 1 of any year, a calendar year shall be deemed to be the continuous period of time between the date coverage became effective and December 31 of that year.

Class A Services Basic services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and radiographic images.

Class B Services Intermediate services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.

Class C Services Major services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.

Class D Services Orthodontic services.

Coinsurance Coinsurance is the stated percentage of covered expenses you must pay.

Copay/Copayment A copayment is a fixed amount of money you pay to the provider when you receive services.

Cosmetic Procedure A cosmetic procedure is any procedure or portion of a procedure performed primarily to improve physical appearance or is performed for psychological purposes.

Covered Provider A covered provider is any licensed dentist, dental hygienist, or denturist acting within the scope of such license.

Covered Service	Covered services shall include only those services specifically listed in Section 5 Dental Services and Supplies. A covered service must be incurred and completed while the person receiving the service is a covered person. Covered services are subject to plan provisions for exclusions and limitations and meet acceptable standards of dental practice as determined by us.
Enrollee	The Federal employee or annuitant enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Generally Accepted Dental Protocols	Services that are necessary for the treatment of a condition, for which there is reasonable expectation of effective treatment and billed according to guidelines described in the Current Dental Terminology (CDT) guide of dental procedures and nomenclature by the American Dental Association (ADA).
Incur/Incurred	A covered service is deemed incurred on the date care, treatment or service is received.
Maximum Allowable Charge	Maximum allowable charge means the maximum amount allowed by the dental plan for covered services. The maximum allowable charge is based on the general level of charges accepted by other providers in the area for like treatment, procedure or services. Our determination of what is allowable is final for the purpose of determining benefits payable under the dental plan.
Plan Allowance	The amount we use to determine our payment for out-of-network services.
Pre-Treatment Estimate	This is the procedure used by the plan to estimate covered services and the amount that the plan will cover. It is not a guarantee of payment.
Pre-Existing Condition	Any disease or condition of the teeth or supporting structures which were present on the effective date of coverage.
Provider Change	If you change from one provider to another during the course of treatment, or if more than one provider performs the same covered service, we will provide the same amount of benefits as if there had been only one provider involved in your treatment.
Service Dates	For benefit determination purposes, we will use these dates as completion dates for the following covered services: • Full or partial denture: the date the completed appliance is first inserted in the mouth. • Inlay, onlay, crown or fixed bridge including, but not limited to, a Maryland bridge: the date the appliance is permanently cemented in place. • Root canal therapy: the date the canal is permanently filled. • Periodontal surgery: the date the surgery is actually performed. • Any other service: the date the service is actually performed.
Subrogation	If GEHA pays benefits for an illness or injury for which you or your dependent are later compensated or reimbursed from another source, you must refund GEHA from any recovery you or your dependent obtain. All GEHA benefit payments in these circumstances are conditional, and remain subject to our contractual benefit limitations, exclusions and maximums.
Waiting Period	Waiting period for covered services means the period of time between the date a member or eligible dependent is first covered under this GEHA dental plan and the date dental services are covered. There is a 12-month waiting period for Class D benefits on the Standard Option plan. There is no waiting period for Class D benefits on the High Option plan.
We/Us	GEHA Connection Dental Federal®.
You	Enrollee or eligible family member.

Non-FEDVIP Benefits

Connection Vision® powered by EyeMed (877) 808-8538 www.gehadental.com

Free to all GEHA Connection Dental Federal High or Standard Option plan members, you receive vision exam coverage for no additional premium. Through Connection Vision® powered by EyeMed, you and your covered family members each pay only $5 for an annual routine eye exam when you use a qualified EyeMed participating provider. Or, if you seek services from a non-participating provider, you can be reimbursed up to $45 for your annual routine eye exam.

At participating EyeMed locations, GEHA members also receive discounts off the retail price of lenses, frames, specialty items (such as tints, lightweight plastics, scratch-resistant coatings), as well as LASIK and PRK.

For a list of participating locations, select Connection Vision on our website at www.gehadental.com.

You will receive a separate vision ID card from EyeMed to use for these services.

EyeMed will process all in-network claims systematically. Members will be responsible for copays at the time of service. For out-of-network services, you will need to pay in full at the time of service and submit a copy of the itemized receipt with an out-of-network claim form for reimbursement to the following address:

EyeMed Vision Care

Attn: OON Claims

P.O. Box 8504

Mason, OH 45040-7111

Connection Hearing® powered by TruHearing (844) 224-2712 www.TruHearing.com

GEHA members save 30 percent to 60 percent off the average retail price of hearing aids with TruHearing, making it affordable to address your unique hearing needs. TruHearing offers a selection of more than 100 of the latest hearing aids from the top hearing aid manufacturers in the world. Call TruHearing to set up an appointment with a provider in your area, who can give you a hearing exam and recommend the right hearing aids for your lifestyle and budget.

When you use TruHearing, you also get:

- three follow-up visits with a provider for fitting and adjustments;
- a 45-day money-back guarantee;
- three-year manufacturer's warranty for repairs and one-time loss and damage replacement; and
- 48 free batteries per aid.

TruHearing is a free program available to all GEHA members and their families, including over-age children, domestic partners, same-sex spouses, parents and grandparents.

Life Alert® Emergency Response (800) 640-0036 www.lifealert.com

All GEHA members and their extended families (including over-age children, domestic partners, same-sex spouses, parents and grandparents) can take advantage of a special discount for Life Alert protection services. To receive this exclusive GEHA discount (free activation plus a 10% discount on your monthly billing), call (800) 640-0036 and request a free Life Alert brochure. A representative will follow up after the brochure arrives to discuss your options.

Every 10 minutes, Life Alert saves a life from a catastrophe. The "Help, I've fallen and I can't get up!" company saves lives during emergencies such as medical, falls, fire, invasion and CO gas poisonings, and has been doing so for the past 30 years. Get emergency help fast, 24/7, even if you can't reach a phone. Get peace of mind for you and your loved ones.

Smile Brilliant	(855) 944-8361	www.smilebrilliant.com/geha

GEHA members save 20% off of the lowest-published price for professional teeth-whitening. Smile Brilliant's custom-fitted trays, teeth whitening gel and desensitizing gel can be ordered online at www.smilebrilliant.com/geha. Orders deliver in 2-3 business days. Use the tray creation kit to make both upper and lower dental impressions. An envelope with pre-paid postage is provided for you to return your dental impressions to Smile Brilliant's dental lab. Custom-fitted trays will be created and shipped within 8 business days. Supplies may be returned to Smile Brilliant within 30 days for a full refund if you are not 100% satisfied. Replacement trays may be purchased within two years for $19.95 plus shipping.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Dental and Vision Insurance Program premium.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, the plan, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your explanation of benefits (EOBs) statements.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at (877) 434-2336 and explain the situation, you will be required to state your complaint in writing to us.
- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self- support).

If you have any questions about the eligibility of a dependent, please contact BENEFEDS.

Be sure to review Section 1, Eligibility, of this brochure prior to submitting your enrollment or obtaining benefits.

Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the plan, or enroll in the plan when you are no longer eligible.

Summary of Benefits

- **Do not rely on this chart alone.** This page summarizes specific expenses we cover; for more details, please review the individual sections of this brochure.
- If you want to enroll or change your enrollment in this plan, please visit www.BENEFEDS.com or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680.

High Option Benefits	You Pay In-network	You Pay Out-of-network	Page
Class A (Basic) Services – preventative and diagnostic	Nothing	Any difference between the plan allowance and the billed amount.	17
Class B (Intermediate) Services – includes minor restorative services	20%	20% of the plan allowance and any difference between our allowance and the billed amount.	19
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	50%	50% of the plan allowance and any difference between our allowance and the billed amount.	23
Class D Services – orthodontic $2,500 Lifetime Maximum	30%	30% of the plan allowance and any difference between our allowance and the billed amount.	30

Please Note: Class A, B, and C Services are subject to a $35,000 annual maximum benefit

Standard Option Benefits	You Pay In-network	You Pay Out-of-network	Page
Class A (Basic) Services – preventative and diagnostic	Nothing	Any difference between the plan allowance and the billed amount.	17
Class B (Intermediate) Services – includes minor restorative services	45%	45% of the plan allowance and any difference between our allowance and the billed amount.	19
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	65%	65% of the plan allowance and any difference between our allowance and the billed amount.	23
Class D Services – orthodontic $2,500 Lifetime Maximum	30%	30% of the plan allowance and any difference between our allowance and the billed amount.	30

Please Note: Class A, B, and C Services are subject to a $2,500 annual maximum benefit

Rate Information

How to find your rate

- In the first chart below, look up your state or ZIP code to determine your Rating Area.
- In the second chart below, match your Rating Area to your enrollment type and plan option.

Premium Rating Areas by State/ZIP Code (first three digits)							
AK entire state	5	IN 463,464	3	NE entire state	1	TN 422	1
AL entire state	1	IN rest of state	1	NH entire state	4	TN rest of state	2
AR entire state	1	KS entire state	2	NJ 080-084	3	TX entire state	2
AZ entire state	2	KY 410, 452, 459	2	NJ rest of state	5	UT entire state	1
CA 939-941, 943-952, 954	5	KY rest of state	1	NM entire state	3	VA 201, 205, 220-227	4
CA rest of state	4	LA entire state	2	NV entire state	3	VA rest of state	2
CO entire state	4	MA entire state	4	NY 005, 100-119, 124-126	5	VT entire state	2
CT 064-069	5	MD 205-212, 214, 217	4	NY 063	4	WA 980-985	5
CT rest of state	4	MD 219	3	NY rest of state	2	WA 986	3
DC entire state	4	MD rest of state	2	OH 430-432,440-443	2	WA rest of state	4
DE entire state	3	ME 038	4	OH 450-455	2	WI 540	3
FL 330-334	3	ME rest of state	3	OH rest of state	1	WI rest of state	2
FL rest of state	2	MI 480-485	3	OK entire state	2	WV 254	4
GA 300-303, 305, 311, 399	3	MI rest of state	2	OR entire state	3	WV rest of state	2
GA rest of state	2	MN 550-555, 563	3	PA 173-174	4	WY 834	2
HI entire state	3	MN rest of state	2	PA 183	5	WY rest of state	1
IA entire state	1	MO entire state	2	PA 189-196	3	PR entire territory	1
ID entire state	2	MS entire state	1	PA rest of state	1	GU entire territory	1
IL 600-608	3	MT entire state	2	RI entire state	4	VI entire territory	1
IL rest of state	1	NC entire state	2	SC entire state	2	International	1
IN 460-462, 470, 472	2	ND entire state	1	SD entire state	1		

Monthly Rates

Rating Area	High Option Self Only	High Option Self Plus One	High Option Self and Family	Standard Option Self Only	Standard Option Self Plus One	Standard Option Self and Family
1	$34.60	$69.20	$103.81	$20.13	$40.26	$60.39
2	$38.03	$76.03	$114.12	$22.08	$44.16	$66.21
3	$43.14	$86.30	$129.42	$25.07	$50.07	$75.10
4	$46.56	$93.12	$139.73	$27.04	$54.04	$81.03
5	$51.65	$103.37	$155.16	$29.97	$59.93	$89.90
International	$34.60	$69.20	$103.81	$20.13	$40.26	$60.39

Biweekly Rates

Rating Area	High Option Self Only	High Option Self Plus One	High Option Self and Family	Standard Option Self Only	Standard Option Self Plus One	Standard Option Self and Family
1	$15.97	$31.94	$47.91	$9.29	$18.58	$27.87
2	$17.55	$35.09	$52.67	$10.19	$20.38	$30.56
3	$19.91	$39.83	$59.73	$11.57	$23.11	$34.66
4	$21.49	$42.98	$64.49	$12.48	$24.94	$37.40
5	$23.84	$47.71	$71.61	$13.83	$27.66	$41.49
International	$15.97	$31.94	$47.91	$9.29	$18.58	$27.87