G.E.H.A Connection Dental Federal®

https://www.geha.com/membership/dental-welcome

1-877-434-2336

G.E.H.A Government Employees Health Association

2027

A Nationwide Dental PPO Plan

Who may enroll in this Plan: All Federal and U.S. Postal Service (USPS) employees, DC Court employees, certain seasonal, intermittent, and temporary employees, annuitants, survivor annuitants, compensationers, certain firefighters and emergency response personnel, and uniformed services retirees.

IMPORTANT

- Rates: Back Cover
- Changes for 2027: Page 4
- Summary of Benefits: Page 53

This Plan has 5 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 and Family**

FEDVIP
Federal Employees Dental And Vision Insurance Program

Authorized for distribution by the:

United States Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

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 law 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. Section 715 of the National Defense Authorization Act for Fiscal Year 2017 (FY 2017 NDAA), Public Law 114-328, expanded FEDVIP eligibility to certain TRICARE-eligible individuals.

This brochure describes the benefits of G.E.H.A Connection Dental Federal® under Government Employees Health Association, Inc.'s contract OPM02-FEDVIP-02AP-08 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

G.E.H.A Connection Dental Federal
310 NE Mulberry St
Lee's Summit, MO 64086
(877) GEHA-DEN or (877) 434-2336
www. geha.com/FEDVIPInfo

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, 2027, 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.

G.E.H.A 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. geha.com/FEDVIPInfo. 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 them 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 G.E.H.A Connection Dental Federal® plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program / Postal Service Health Benefits (PSHB) 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. geha.com/FEDVIPInfo. 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
G.E.H.A Connection Dental Federal complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, G.E.H.A Connection Dental Federal does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

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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. Some TRICARE beneficiaries may not be eligible to enroll in both. Visit www.opm.gov/dental or www.opm.gov/vision for more information.
Enroll Through BENEFEDS	You enroll online at www.BENEFEDS.gov. Please see Section 2, Enrollment, for more information.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2026 Open Season, your coverage will begin on January 1, 2027. Premium deductions will start with the first full pay period beginning on/after January 1, 2027. 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. TRICARE enrollees automatically pay premiums through payroll deduction or automatic bank withdrawal (ABW) 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 09, 2026, through midnight EST December 14, 2026. 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.
Compliance with the American Dental Association (ADA)	FEDVIP abides by the Current Dental Terminology (CDT) codification system in accordance with standards set by the American Dental Association (ADA). *Current Dental Terminology (CDT)*, Copyright © American Dental Association. All rights reserved.

How We Have Changed For 2027

Benefit Changes:

High and Standard Options:

- We added the following procedure codes:

- D6197 Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant (Class C)

- We updated the following procedure codes:

- D0220 Intraoral – periapical first radiographic image and D0230 Intraoral – periapical each additional radiographic image - *Combined and limited to no more than 4 per date of service and not to exceed 10 in a calendar year* (Class A)
- D2991 Application of hydroxyapatite regeneration medicament - per tooth - *Limited to 1 per tooth per calendar year* (Class B)

- Get access to the new G.E.H.A Member Discount Program with discounts on travel, fitness, personal care, groceries, electronics, childcare, senior care and more.

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, the Postal Service Health Benefits (PSHB) 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, PSHB Program or a Health Insurance Marketplace (Exchange) plan is not required.

Temporary / Seasonal Employees

Certain temporary, intermittent, and seasonal Federal and U.S. Postal Service employees are now eligible to enroll in FEDVIP. To be eligible, these employees must be expected to work 130 hours per calendar month for at least 90 days. In addition, certain firefighters hired under a temporary appointment and intermittent emergency response personnel are eligible to enroll in FEDVIP. The employing agency must determine and notify these employees of their eligibility.

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/PSHB 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.

TRICARE-eligible individual

An individual who is eligible for FEDVIP dental coverage based on the individual's eligibility to previously be covered under the TRICARE Retiree Dental Program or an individual eligible for FEDVIP vision coverage based on the individual's enrollment in a specified TRICARE health plan.

Retired members of the uniformed services and National Guard/Reserve components, including "gray-area" retirees under age 60 and their families are eligible for FEDVIP dental coverage. These individuals, if enrolled in a TRICARE health plan, are also eligible for FEDVIP vision coverage. In addition, uniformed services active duty family members who are enrolled in a TRICARE health plan are eligible for FEDVIP vision coverage.

Family Members

Except with respect to TRICARE-eligible individuals, 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/PSHB 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.

With respect to TRICARE-eligible individuals, family members include your spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in your legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.

Not Eligible

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

- Deferred annuitants
- Former spouses of employees or annuitants. **Note:** Former spouses of TRICARE-eligible individuals may enroll in a FEDVIP vision plan.
- FEHB/PSHB Temporary Continuation of Coverage (TCC) enrollees
- Anyone receiving an insurable interest annuity who is not also an eligible family member.
- Active duty uniformed service members. **Note:** If you are an active duty uniformed service member, your dental and vision coverage will be provided by TRICARE. Your family members will still be eligible to enroll in the TRICARE Dental Plan (TDP).
- Temporary/seasonal employees who do not meet the 130 hours per calendar month for 90 days.

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.gov) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY: 711, International: 1-571-730-5942 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 2027.

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, annuitant, or TRICARE-eligible individual, you may enroll in a dental and/or vision plan during the November 09, 2026, through midnight EST December 14, 2026, Open Season. Coverage is effective January 1, 2027.

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;
- an employee returning to service following a break in service of at least 31 days; or
- a TRICARE-eligible individual.

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: Marriage
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes

Qualifying Life Event: Acquiring an eligible family member (non-spouse)
From Not Enrolled to Enrolled: No
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Losing a covered family member
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: Yes
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Losing other dental/vision coverage (eligible or covered person)
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Moving out of regional plan's service area
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes

Qualifying Life Event: Going on active military duty, non-pay status (enrollee or spouse)
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: Yes
Change from One Plan to Another: No

Qualifying Life Event: Returning to pay status from active military duty (enrollee or spouse)
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Returning to pay status from Leave without pay
From Not Enrolled to Enrolled: Yes (if enrollment cancelled during LWOP)
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes (if enrollment cancelled during LWOP)

Qualifying Life Event: Annuity/ compensation restored
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Transferring to an eligible position*
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: Yes
Change from One Plan to Another: No

*Position must be in 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 a loss of dental or vision insurance. You must make the change no later than 60 days after the event.

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.

VA Exception for Cancellation

Generally, you may cancel your enrollment only during the annual open season. However, if you are a FEDVIP enrollee paying premiums on a **post-tax basis**, and you, your family member, or TRICARE-eligible individual (TEI) family member becomes eligible for VA dental or vision benefits, then you **may** change your enrollment type or cancel your enrollment within 60 days of receiving notification of VA dental or vision eligibility. This 60-day period may fall outside of open season. VA dental or vision eligibility documentation must be submitted to OPM via the BENEFEDS mailbox (benefedsportal@opm.gov) within 60 days of notification to support the FEDVIP enrollment change or cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the open season effective date. An eligible family member's coverage also ends upon the effective date of the cancellation.

If you are a FEDVIP enrollee paying premiums on a **pre-tax basis,** and you, your family member, or TEI family member becomes eligible for VA dental or vision benefits, then you **may not** change or cancel your FEDVIP enrollment until the next open season.

FEDVIP enrollees can verify if they are paying their premiums on a pre- or post-tax basis by contacting BENEFEDS at 1-877-888-3337, TTY: 711, International: 1-571-730-5942.

When Coverage Stops

Coverage ends for active and retired Federal, U.S. Postal employees, and TRICARE-eligible individuals when you:

- no longer meet the definition of an eligible employee, annuitant, or TRICARE-eligible individual;
- as a Retired Reservist you begin active duty;
- as sponsor or primary enrollee leaves active duty;
- 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 a FSAFEDS HealthCare Flexible Spending Account (HCFSA), Limited Expense Health Care Flexible Spending Account (LEX HCFSA), or any flexible spending account, 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.

Please review IRS - Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans (https://www.irs.gov/forms-pubs/about-publication-969) for additional information about carryover and contribution amounts for the upcoming tax year. If you have an HCFSA or LEX HCFSA FSAFEDS account and you have not exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over a set maximum amount 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 31st. 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 meet the minimum contribution amount for the plan year. 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 permitted. This is known as the "Use-it-or-Lose-it" rule. Carefully consider the amount you will elect.

Current FSAFEDS participants must re-enroll to participate in the program next year. See https://www.fsafeds.gov or call 1-877-FSAFEDS (372-3337) or TTY: 1-866-353-8058. **Note: FSAFEDS is not open to retired employees or to TRICARE eligible individuals.**

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

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation

We will send you an identification (ID) card when you enroll within 15 days of your effective date. 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: G.E.H.A Enrollment, P.O. Box 21262, Eagan, MN 55121.

Existing members who were previously issued an ID card will not receive new ID cards unless otherwise requested or G.E.H.A receives a name change/correction or change in plan from BENEFEDS.

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

It is important to bring your FEDVIP and FEHB/PSHB identification cards to every dental appointment because most FEHB/PSHB 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.geha.com/find-dental-care. 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 preferred dentists can be obtained free of charge. Visit our website at www.geha.com/find-dental-care 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.

G.E.H.A 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. G.E.H.A reimburses for covered dental care from any covered provider. Non-PPO providers have no agreement to limit what they will bill you.

Pre-Determination

The plan does not require a pre-determination of benefits. G.E.H.A will respond to a request to pre-determine services with an estimate of covered service, which is non-binding and 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-determination for any extensive treatment. By obtaining a pre-determination, 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.

Pre-determinations are valid through the calendar year in which they are prepared, or 12-months, subject to eligibility and plan limitations.

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.

FEHB/PSHB First Payor

When you visit a provider who participates with both your FEHB/PSHB plan and your FEDVIP plan, the FEHB/PSHB plan will pay benefits first. In these cases, the FEDVIP plan's allowable will be the lesser of: (a) the negotiated allowable charge between the FEDVIP plan and the provider; or (b) the negotiated allowable charge between the FEHB/PSHB plan and the provider.

You are responsible for the difference between the total FEHB/PSHB and FEDVIP payments and the allowable as defined above.

We are responsible for facilitating the process with the primary FEHB/PSHB first payor.

It is important to bring your FEDVIP and FEHB/PSHB identification cards to every dental appointment because most FEHB/PSHB 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.

Example: Provider is in-network with both FEDVIP plan and FEHB/PSHB plan. The provider can collect up to the lowest allowable as payment in full.

FEDVIP G.E.H.A high option member with FEHB/PSHB coverage FEHB/PSHB plan is always primary payor G.E.H.A Connection Dental Federal high option plan is secondary
Charges by an **In-Network Provider**
Extraction of tooth: $150.00
Primary FEHB/PSHB allowable: $123.00
Primary FEHB/PSHB payment (estimated): $21.00
FEDVIP allowable: $131.00
FEDVIP payment: $123.00 X 80% = $98.40
Total of primary payment and FEDVIP Payments: $21.00 + $98.40 = $119.40
Patient responsibility: $123.00 - $119.40 = $3.60

Example: Provider is out-of-network with both FEDVIP plan and FEHB/PSHB plan. The provider can collect up to their billed charge.

FEDVIP G.E.H.A high option member with FEHB/PSHB coverage. FEHB/PSHB plan is always primary payor. G.E.H.A Connection Dental Federal high option plan is secondary
Charges by **Out-of-Network Provider**
Extraction of tooth: $150.00
Primary FEHB/PSHB payment (estimated): $21.00
FEDVIP allowable: $131.00
FEDVIP payment: $131.00 X 80% = $104.80
Total of primary payment and FEDVIP payments: $21.00 + $104.80 = $125.80
Balance which is patient responsibility: $150.00 - $125.80 = $24.20

Coordination of Benefits

We determine which non-FEHB/non-PSHB coverage is primary according to National Association of Insurance Commissioners' (NAIC) guidelines. When you visit a provider who participates with both your FEHB/PSHB plan and your FEDVIP plan, refer to the "FEHB/PSHB First Payor" section. 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.

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

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/PSHB medical plan before we calculate benefits payable by us. In addition to benefits payable by your FEHB/PSHB medical plan, if you or your covered dependents have other dental coverage, you must tell G.E.H.A. When we are secondary or tertiary (third) payor, our payment will be the lesser of the following:

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

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

Example: Provider is in-network with both FEDVIP plan and other plan. The provider can collect up to the lowest allowable as payment in full.

FEDVIP G.E.H.A high option member with other plan coverage
G.E.H.A Connection Dental Federal high option plan is secondary
Charges by **In-Network Provider**
Extraction of tooth: $150.00
Primary allowable: $123.00
Primary payment: $21.00
FEDVIP allowable: $131.00
FEDVIP payment: $123.00 X 80% = $98.40
Total of primary payment and FEDVIP payments: $21.00 + $98.40 = $119.40
Patient responsibility: $123.00 - $119.40 = $3.60

Example: Provider is out-of-network with both FEDVIP plan and other plan. The provider can collect up to their billed charge.

FEDVIP G.E.H.A high option member with other plan coverage
G.E.H.A Connection Dental Federal high option plan is secondary
Charges by **Out-of-Network Provider**
Extraction of tooth: $150.00
Primary payment: $21.00
FEDVIP allowable: $131.00
FEDVIP payment: $131.00 X 80% = $104.80
Total of primary payment and FEDVIP payments: $21.00 + $104.80 = $125.80
Balance which is patient responsibility: $150.00 - $125.80 = $24.20

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

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.gov or by phone at (877) 888-3337, TTY 711, International 1-571-730-5942. 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 general dentists 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-determination 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. The tooth number is required with claim submission to avoid claim processing delays. Radiographic images are required for crowns, periodontal procedures, inlays/onlays, anterior and multiple restorations, crown build-ups and implants. The complete treatment plan is also needed for implants. Charting is required for periodontal procedures. The date (month and year) of prior placement is required for replacement dentures, partials, crowns and bridges. The degree and classification of malocclusion is required for orthodontics.

Crown – A pre-operative bitewing and periapical radiographs are required to determine if services meet benefit guidelines for coverage. Date (month/date/year) of any prior crown is required, if replacement.

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/date/year) of any prior prosthesis replacing tooth/teeth to be replaced with implant(s).

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

- Classification of malocclusion (this means Class I, II, III), including narrative
- Degree of overjet, in mm
- Degree of overbite, in mm
- Anterior crowding discrepancy in mm
- Anterior spacing discrepancy in mm
- Description, if any, of cross bite
- Total number of months required for treatment
- Treatment objective
- Cephalometric image or tracing, if available
- Panoramic radiographic image
- Diagnostic photos

Periodontal – Full mouth or panoramic radiographs including current bitewing radiographs, periodontal charting, provider narrative and any additional diagnostic information necessary to determine if services meet benefit guidelines for coverage.

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.

G.E.H.A Connection Dental Federal® **High Option** – no copay.

G.E.H.A Connection Dental Federal® **Standard Option** – no copay.

Deductible

A deductible is a fixed amount of expenses you must incur for certain covered services before we will pay for covered services. Covered charges credited to the deductible are also counted towards the Plan maximum and limitations.

There is no calendar year deductible for High Option or Standard in-network. Standard Option out-of-network services under Class A, B and C are subject to a combined $75 deductible per person, per calendar year.

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:

In-Network

- Class A – nothing
- Class B – 45%
- Class C – 65%
- Class D – 50%

Out-of-Network

- Class A – 25%
- Class B – 50%
- Class C – 70%
- Class D – 50%

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 unlimited annual benefit maximum per person 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 in-network services and $2,000 for out-of-network services 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 $3,500 per person for High Option and $2,500 for in-network Class D services, $1,500 for out-of-network Class D services for Standard Option. 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 preferred 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. The plan allowance may vary upon geographic location and/or a participating providers contracted fee schedule. 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. G.E.H.A may collect the overpayment from the member if G.E.H.A has exhausted every effort to recover an overpayment made to a provider. Federal Laws supersede State Laws regarding our right to recovery of overpayments.
Subrogation	If G.E.H.A pays benefits for an illness or injury for which you or your dependent are later compensated or reimbursed from another source, you must refund G.E.H.A from any recovery you or your dependent obtain. All G.E.H.A 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.
In-Progress Treatment	In-progress treatment for dependents of retiring active-duty service members who were enrolled in the TRICARE Dental Program (TDP) will be covered for the 2027 plan year, regardless of any current plan exclusion for care initiated prior to the enrollee's effective date. This requirement includes assumption of payments for covered orthodontia services up to the FEDVIP policy limits, and full payment where applicable up to the terms of FEDVIP policy for covered services completed (but not initiated) in the 2027 plan year such as crowns and implants.

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 High Option or Standard Option in-network. Standard out-of-network Services under Class A, B and C are Subject to a combined $75 Deductible per person, per calendar year.
- The High Option annual benefit maximum is unlimited per covered person.
- The Standard Option annual benefit maximum is $2,500 for in-network services and $2,000 for out-of-network services 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 and the other limitations described in this plan document.
- Bitewing Radiographic images are limited to twice per Calendar Year for children 22 and younger and once per Calendar Year for adults age 23 and older.

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:** 25% and any difference between the plan allowance and the billed amount. Subject to the deductible.

Diagnostic Services

D0140 Limited oral evaluation – problem focused – *will be allowed per patient per dentist in a 12 consecutive month period*

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver

D0150 Comprehensive oral evaluation – new or established patient

D0180 Comprehensive periodontal evaluation – new or established patient

D0210 Intraoral – comprehensive series of radiographic images – *Full mouth radiographic images and panoramic radiographic image are limited to a combined maximum of once every 3 Calendar Years*

D0220 Intraoral – periapical first radiographic image - *Combined with D0230 Intraoral - periapical each additional radiographic image and limited to no more than 4 per date of service and not to exceed 10 in a Calendar Year*

D0230 Intraoral – periapical each additional radiographic image -*Combined with D0220 Intraoral - periapical first radiographic image and limited to no more than 4 per date of service and not to exceed 10 in a Calendar Year*

D0240 Intraoral – occlusal radiographic image

D0250 Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector

D0251 Extra-oral posterior dental radiographic image

D0270 Bitewing – single radiographic image

Diagnostic Services - continued on next page

Diagnostic Services (cont.)
D0272 Bitewings – two radiographic images
D0273 Bitewings – three radiographic images
D0274 Bitewings – four radiographic images
D0277 Vertical bitewings – 7 to 8 radiographic images
D0330 Panoramic radiographic image – *Full mouth radiographic images and panoramic radiographic image are limited to a combined maximum of once every 3 Calendar Years*
D0425 Caries susceptibility tests

Class A Diagnostic Services Limitations and Notes:

- Routine oral evaluations are combined and limited to twice per calendar year.
  - *Oral evaluations (D0120 Periodic oral evaluation – established patient, D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver, D0150 Comprehensive oral evaluation – new or established patient,* D0180 Comprehensive periodontal evaluation – new or established patient) are limited to a maximum of two times per Calendar Year.
- Intraoral occlusal, extra-oral 2D and extra-oral posterior x-rays are limited to a combined maximum of 4 per Calendar Year.
- Bitewing radiographs are combined and limited to twice per calendar year for individuals age 22 and under and once per calendar year for individuals age 23 and over.
  - *This includes D0270 Bitewing – single radiographic image, D0272 Bitewings – two radiographic images, D0273 Bitewings – three radiographic images, D0274 Bitewings – four radiographic images and D0277 Vertical bitewings – 7 to 8 radiographic images.*

Preventive services
D1110 Prophylaxis – adult – *If enrolled in Standard Option, limited to twice per Calendar Year. If enrolled in High Option, limited to three per Calendar Year*
D1120 Prophylaxis – child – *Limited to twice per Calendar Year*
D1206 Application of medicament - topical fluoride varnish; full mouth
D1208 Application of medicament - topical fluoride - excluding varnish; full mouth
D1351 Sealant – per tooth
D1353 Sealant repair – per tooth – *Limited to once per tooth, per lifetime*
D1354 Application of caries arresting medicament without surgical intervention - per tooth – *Per lifetime, limited to children under 9 years of age*
D1510 Space maintainer – fixed, unilateral – per quadrant
D1516 Space maintainer – fixed – bilateral, maxillary
D1517 Space maintainer – fixed – bilateral, mandibular
D1520 Space maintainer – removable, unilateral - per quadrant
D1526 Space maintainer – removable – bilateral, maxillary
D1527 Space maintainer – removable – bilateral, mandibular
D1551 Re-cement or re-bond bilateral space maintainer – maxillary – *Limited twice per Calendar Year combined with D1552 Re-cement or re-bond bilateral space maintainer – mandibular and D1553 Re-cement or re-bond unilateral space maintainer – per quadrant*
D1552 Re-cement or re-bond bilateral space maintainer – mandibular – *Limited twice per Calendar Year combined with D1551 Re-cement or re-bond bilateral space maintainer – maxillary and D1553 Re-cement or re-bond unilateral space maintainer – per quadrant*
D1553 Re-cement or re-bond unilateral space maintainer – per quadrant – *Limited twice per Calendar Year combined with D1551 Re-cement or re-bond bilateral space maintainer – maxillary and D1552 Re-cement or re-bond bilateral space maintainer – mandibular*
D1575 Distal shoe space maintainer – fixed, unilateral – per quadrant

Preventive services - continued on next page

Preventive services (cont.)

Class A Preventive Services Limitations and Notes:

- Topical application of fluoride is limited to covered persons under age 22 twice per Calendar Year
- Sealants are limited to Covered Persons under 18 years of age on unrestored permanent molars only and are limited to one sealant per tooth every 3 Calendar Years, which includes D1351 Sealant - per tooth
- Space maintainers are limited to initial appliance, no more than one per tooth, which includes:
  - D1510 Space maintainer – fixed, unilateral – per quadrant, D1516 Space maintainer – fixed – bilateral, maxillary,
  - D1517 Space maintainer – fixed – bilateral, mandibular, D1520 Space maintainer – removable, unilateral – per quadrant,
  - D1526 Space maintainer – removable – bilateral, maxillary, D1527 Space maintainer – removable – bilateral, mandibular and
  - D1575 Distal shoe space maintainer – fixed, unilateral – per quadrant, for non-orthodontic treatment of prematurely lost teeth in children under age 19

Additional procedures covered as basic services

D1321 Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use – *Limited to once per lifetime*

D9110 Palliative treatment of dental pain – per visit

D9310 Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician – *Limited to once per patient, per provider (dentist) per lifetime*

D9311 Consultation with a medical health care professional – *Limited to once per Covered Person per lifetime*

D9440 Office visit – after regularly scheduled hours

Services Not Covered

- **Refer to Section 7 for a list of general exclusions**

Current Dental Terminology **© American Dental Association**

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 High Option or Standard Option in-network. Standard Option out-of-network Services under Class A, B and C are subject to a combined $75 Deductible per person, per calendar year.
- The High Option annual benefit maximum is unlimited per covered person.
- The Standard Option annual benefit maximum is $2,500 for in-network, $2,000 for out-of-network 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 and the other limitations described in this document.
- The dental plan does not require a pre-determination of benefits. G.E.H.A 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-determination for any extensive treatment. By obtaining a pre-determination, 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.
- In-progress treatment for dependents of retiring TDP enrollees will be covered for the 2027 plan year. This is regardless of any current plan exclusions for care initiated prior to the enrollee's effective date.

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:** 50% of the plan allowance and any difference between our allowance and the billed amount. Subject to the deductible.

Minor restorative services
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 (anterior)
D2390 Resin-based composite crown - direct – *Limited to anterior primary teeth only, once per tooth, per lifetime*
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, onlay, veneer or partial coverage restoration – *Limited to once per 6 month period if more than 12-months from initial placement*
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core – *Limited to once per tooth, per lifetime*
D2920 Re-cement or re-bond crown – *Limited to once per 6 month period if more than 12-months from initial placement*
D2921 Reattachment of tooth fragment, incisal edge or cusp – *Limited to once per tooth, per lifetime*
D2929 Prefabricated porcelain/ceramic crown - primary tooth – *Limited to one per patient, per tooth, per lifetime for Covered Persons under 15 years of age*
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
D2989 Excavation of a tooth resulting in the determination of non-restorability – *Limited to once per tooth, per lifetime*
D2991 Application of hydroxyapatite regeneration medicament – per tooth – *Limited to 1 per Calendar Year, per tooth*
Class B Minor Restorative Services Limitations and Notes:
• Restorations are limited to one restoration per tooth surface every 2 Calendar Years

Endodontic services
D3110 Pulp cap – direct (excluding final restoration) – *Coverage determined by report*
D3120 Pulp cap – indirect (excluding final restoration) – *Coverage determined by report*
D3220 Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament – *Limited to once per tooth, per lifetime*
D3221 Pulpal debridement, primary and permanent teeth – *Limited to once per tooth, per lifetime*
D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development – *Limited to once per tooth, per lifetime*
D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) – *Limited to primary incisor teeth for children up to age 6 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) – *Limited to primary molars for children up to age 11 and is limited to once per tooth, per lifetime*
D3921 Decoronation or submergence of an erupted tooth

Periodontal services
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*
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
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 – *Coverage determined by report*

Class B Periodontal Services Limitations and Notes:

- *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*
- *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. This service replaces a routine prophylaxis for the calendar year in which it was performed*
- *D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - 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. Limited to once per tooth, per lifetime. Coverage determined by report*

Prosthodontic services
D5410 Adjust complete denture – maxillary
D5411 Adjust complete denture – mandibular
D5421 Adjust partial denture – maxillary
D5422 Adjust partial denture – mandibular
D5511 Repair complete denture base, mandibular
D5512 Repair complete denture base, maxillary
D5520 Replace missing or broken teeth – complete denture– per tooth
D5611 Repair resin partial denture base, mandibular
D5612 Repair resin partial denture base, maxillary
D5621 Repair cast partial framework, mandibular
D5622 Repair cast partial framework, maxillary
D5630 Repair or replace broken retentive clasping materials – per tooth
D5640 Replace missing or broken teeth – partial denture – per tooth
D5650 Add tooth to existing partial denture – per tooth
D5660 Add clasp to existing partial denture – per tooth
D5670 Replace all teeth and acrylic on cast metal framework (maxillary)
D5671 Replace all teeth and acrylic on cast metal framework (mandibular)
D5710 Rebase complete maxillary denture
D5711 Rebase complete mandibular denture
D5720 Rebase maxillary partial denture
D5721 Rebase mandibular partial denture
D5725 Rebase hybrid prosthesis
D5730 Reline complete maxillary denture (direct)
D5731 Reline complete mandibular denture (direct)
D5740 Reline maxillary partial denture (direct)
D5741 Reline mandibular partial denture (direct)

Prosthodontic services - continued on next page

Prosthodontic services (cont.)
D5750 Reline complete maxillary denture (indirect)
D5751 Reline complete mandibular denture (indirect)
D5760 Reline maxillary partial denture (indirect)
D5761 Reline mandibular partial denture (indirect)
D5765 Soft liner for complete or partial removable denture – indirect
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*
D6930 Re-cement or re-bond fixed partial denture – *Recement of fixed partial denture, or bridge is limited to one per Calendar Year, after 6 months of initial placement*
D6980 Fixed partial denture repair necessitated by restorative material failure – *Coverage determined by report*

Class B Prosthodontic Services Limitations and Notes:

- Adjustment or repair to denture or partial denture are limited to two per Calendar Year, at least 6 months after delivery of appliance
- Replacement of all teeth and acrylic on cast metal framework is limited to once every five Calendar Years
- Tissue conditioning, rebase and reline of dentures is limited to a maximum of once every 3 Calendar Years after 6 months of initial placement

Oral surgery
D7111 Extraction, coronal remnants – primary 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
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, impacted teeth only
D7270 Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Exposure of an unerupted tooth – *Limited to one per tooth, per lifetime*
D7310 Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant
D7311 Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant
D7321 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7471 Removal of lateral exostosis (maxilla or mandible)
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– *Coverage determined by report*

Class B Oral Surgery Services Limitations and Notes:

- 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
- D7999 Unspecified oral surgery procedure, by report - *Coverage determined by report. The plan allowance will be determined upon review of the report*

Oral surgery - continued on next page

Oral surgery (cont.)

Services Not Covered

- Refer to Section 7 for a list of general exclusions

***Current Dental Terminology* © American Dental Association**

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 High Option or Standard Option in-network. Standard Option out-of-network Services under Class A, B and C are subject to a combined $75 Deductible per person, per calendar year.
- The High Option annual benefit maximum is unlimited per covered person.
- The Standard Option annual benefit maximum is $2,500 for in-network, $2,000 for out-of-network per covered person.
- Implant services are limited to an annual maximum of $2,500 per covered person included in the annual benefit maximum. Standard Option out-of-network services are limited to an annual maximum of $2,000 per covered person, included in the annual benefit maximum.
- Class C Major services are subject to a 5-year limitation.
- 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 and the other limitations described in this plan document.
- The dental plan does not require a pre-determination of benefits. G.E.H.A 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-determination for any extensive treatment. By obtaining a pre-determination, 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.
- This plan only provides benefits for the replacement of a complete denture, partial denture, fixed bridge, implant crown, implant complete denture and implant partial denture with a like prosthesis. Upgrading the appliance will not be covered.
- Prosthetic replacement of teeth is covered only 5 years after teeth were replaced previously and only if prior prosthesis cannot be made serviceable.
- In-progress treatment for dependents of retiring TDP enrollees will be covered for the 2027 plan year. This is regardless of any current plan exclusions for care initiated prior to the enrollee's effective date.
- After 12-months provisional/temporary restorations are considered permanent restorations and will be subject to the 5-year replacement rule.

		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:** 70% of plan allowance and any difference between our allowance and the billed amount. Subject to the deductible.	

Major restorative services

D0160 Detailed and extensive oral evaluation – problem focused, by report – *Detailed and extensive oral evaluations are limited to once per covered persons per dentist, per lifetime*
*D2510 Inlay – metallic – one surface
*D2520 Inlay – metallic – two surfaces
*D2530 Inlay – metallic – three or more surfaces
*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
*D2750 Crown – porcelain fused to high noble metal
*D2751 Crown – porcelain fused to predominantly base metal
*D2752 Crown – porcelain fused to noble metal
*D2753 Crown – porcelain fused to titanium and titanium alloys
*D2780 Crown – 3/4 cast high noble metal
D2781 Crown – 3/4 cast predominantly 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 predominantly base metal
*D2792 Crown – full cast noble metal
*D2794 Crown – titanium and titanium alloys
D2950 Core buildup, including any pins when required
*D2952 Post and core in addition to crown, indirectly fabricated
*D2953 Each additional indirectly fabricated post – same tooth

Major restorative services - continued on next page

Major restorative services (cont.)
D2954 Prefabricated post and core in addition to crown
*D2957 Each additional prefabricated post – same tooth
D2980 Crown repair necessitated by restorative material failure – *Coverage determined by report*
D2981 Inlay repair necessitated by restorative material failure – *Coverage determined by report*
D2982 Onlay repair necessitated by restorative material failure – *Coverage determined by report*
D2983 Veneer repair necessitated by restorative material failure – *Coverage determined by report*
D2990 Resin infiltration of incipient smooth surface lesions

Class C Major Restorative Services Limitations and Notes:

- Crowns, inlays, onlays and posts and cores are payable only when required for restorative purposes and necessary due to extensive decay or significant tooth fracture and evidence is presented showing the tooth cannot be adequately restored with an amalgam or composite restoration
- D2950 Core buildup, including any pins when required – *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

Endodontic services
D3310 Endodontic therapy, anterior tooth (excluding final restoration) – *Limited to once per tooth, per lifetime*
D3320 Endodontic therapy, premolar tooth (excluding final restoration) – *Limited to once per tooth, per lifetime*
D3330 Endodontic therapy, molar tooth (excluding final restoration) – *Limited to once per tooth, per lifetime*
D3346 Retreatment of previous root canal therapy – anterior
D3347 Retreatment of previous root canal therapy – premolar
D3348 Retreatment of previous root canal therapy – molar
D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) – *Limited to once per tooth, per lifetime*
D3352 Apexification/recalcification – interim medication replacement – *Limited to once per tooth, per lifetime*
D3353 Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.) – *Limited to once per tooth, per lifetime*
D3355 Pulpal regeneration – initial visit - *Coverage determined by report. Limited to once per tooth, per lifetime*
D3356 Pulpal regeneration – interim medication replacement – *Coverage determined by report. Limited to once per tooth, per lifetime*
D3357 Pulpal regeneration – completion of treatment – *Coverage determined by report. Limited to once per tooth, per lifetime*
D3410 Apicoectomy – anterior – *Limited to once per tooth, per lifetime*
D3421 Apicoectomy – premolar (first root) – *Limited to once per tooth, per lifetime*
D3425 Apicoectomy – molar (first root) – *Limited to once per tooth, per lifetime*
D3426 Apicoectomy (each additional root) – *Limited to 2 per tooth on molar teeth, per lifetime, and once per tooth on premolar and anterior teeth, per lifetime*
D3430 Retrograde filling – per root
D3450 Root amputation – per root
D3471 Surgical repair of root resorption – anterior
D3472 Surgical repair of root resorption – premolar
D3473 Surgical repair of root resorption – molar
D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior
D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar
D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption – molar

Endodontic services - continued on next page

Endodontic services (cont.)
D3920 Hemisection (including any root removal), not including root canal therapy
Class C Endodontic Services Limitations and Notes: • Retreatment of root canal is covered only after 12-months from the prior root canal therapy
Periodontal services
D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant
D4211 Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth – *Limited to once per tooth every 2 Calendar Years with restorative procedure*
D4240 Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant
D4241 Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant
D4249 Clinical crown lengthening – hard tissue – *Limited to once per tooth, per lifetime*
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
D4270 Pedicle soft tissue graft procedure – *Charges for guided tissue regeneration and use of collagen are considered components of this procedure*
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft
D4276 Combined connective tissue and pedicle graft, per tooth– *Grafts on additional contiguous teeth payable as secondary procedures*
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit – *Limited to once per lifetime*
D4999 Unspecified periodontal procedure, by report – *Coverage determined by report*

Periodontal services - continued on next page

Periodontal services (cont.)

Class C Periodontal Services Limitations and Notes:

- Gingivectomy, gingivoplasty, gingival flap procedure, and osseous surgery are limited to once per quadrant every 2 Calendar Years and are not covered when treating implant and edentulous areas
- Tissue graft procedures are not covered when treating implants or in edentulous areas for the following codes:
  - D4270 Pedicle soft tissue graft procedure
  - D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft
  - D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft
  - D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft
  - D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site
  - D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
  - D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4999 Unspecified periodontal procedure, by report – *Coverage determined by report. The plan allowance will be determined upon review of the report*

Prosthodontic services

D5110 Complete denture – maxillary
D5120 Complete denture – mandibular
D5130 Immediate denture – maxillary
D5140 Immediate denture – mandibular
D5211 Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)
D5212 Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)
D5213 Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5214 Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5221 Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)
D5222 Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)
D5223 Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5225 Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)
D5226 Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)
D5227 Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)
D5228 Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)
D5282 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary
D5283 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular
D5284 Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant

Prosthodontic services - continued on next page

Prosthodontic services (cont.)
D5286 Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant
D5876 Add metal substructure to acrylic complete denture – per arch – *Coverage determined by report*
D6205 Pontic – indirect resin based composite – *Not to be used as a temporary or provisional prosthesis*
*D6210 Pontic – cast high noble metal
*D6211 Pontic – cast predominantly base metal
*D6212 Pontic – cast noble metal
*D6214 Pontic – titanium and titanium alloys
*D6240 Pontic – porcelain fused to high noble metal
*D6241 Pontic - porcelain fused to predominantly base metal
*D6242 Pontic – porcelain fused to noble metal
*D6243 Pontic – porcelain fused to titanium and titanium alloys
*D6245 Pontic – porcelain/ceramic
*D6545 Retainer – cast metal for resin bonded fixed prosthesis
*D6548 Retainer – porcelain/ceramic for resin bonded fixed prosthesis
*D6549 Retainer – 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
*D6613 Retainer onlay – 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 predominantly base metal
*D6752 Retainer crown – porcelain fused to noble metal
*D6753 Retainer crown – porcelain fused to titanium and titanium alloys
*D6780 Retainer crown – 3/4 cast high noble metal
*D6781 Retainer crown – 3/4 cast predominantly base metal
*D6782 Retainer crown – 3/4 cast noble metal
*D6783 Retainer crown – 3/4 porcelain/ceramic
*D6784 Retainer crown 3/4 - titanium and titanium alloys
*D6790 Retainer crown – full cast high noble metal
*D6791 Retainer crown – full cast predominantly base metal
*D6792 Retainer crown – full cast noble metal
*D6794 Retainer crown – titanium and titanium alloys
Class C Prosthodontic Services Limitations and Notes: *The replacement of a prior 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.*

Implant services
*D6010 Surgical placement of implant body: endosteal implant
*D6013 Surgical placement of mini implant
*D6040 Surgical placement: eposteal implant
*D6050 Surgical placement: transosteal implant
*D6055 Connecting bar – implant supported or abutment supported
*D6056 Prefabricated abutment – includes modification and placement
*D6057 Custom fabricated abutment – includes 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 base metal)
*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 base metal)
*D6064 Abutment supported cast metal crown (noble metal)
*D6065 Implant supported porcelain/ceramic crown
*D6066 Implant supported crown – porcelain fused to high noble alloys
*D6067 Implant supported crown – high noble alloys
*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 FPD – porcelain fused to high noble alloys
*D6077 Implant supported retainer for metal FPD – high noble alloys
D6080 Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments
D6081 Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure – *Limited to a maximum of once every 2 Calendar Years. Coverage determined by report*
*D6082 Implant supported crown – porcelain fused to predominantly base alloys
*D6083 Implant supported crown – porcelain fused to noble alloys
*D6084 Implant supported crown – porcelain fused to titanium and titanium alloys
*D6086 Implant supported crown – predominantly base alloys
*D6087 Implant supported crown – noble alloys
*D6088 Implant supported crown – titanium and titanium alloys
D6089 Accessing and retorquing loose implant screw – per screw
D6090 Repair of implant/abutment supported prosthesis
D6091 Replacement of replaceable part of semi-precision attachment of implant/abutment retained prosthesis, per attachment
D6092 Re-cement or re-bond implant/abutment supported crown
D6093 Re-cement or re-bond implant/abutment supported fixed partial denture
*D6094 Abutment supported crown – titanium and titanium alloys

Implant services - continued on next page

Implant services (cont.)
D6096 Remove broken implant retaining screw
*D6097 Abutment supported crown – porcelain fused to titanium and titanium alloys
*D6098 Implant supported retainer – porcelain fused to predominantly base alloys
*D6099 Implant supported retainer for FPD – porcelain fused to noble alloys
D6100 Surgical removal of implant body
D6102 Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure – *Limited to once per implant, per lifetime*
D6104 Bone graft at time of implant placement
*D6110 Implant /abutment retained removable denture for edentulous arch – maxillary
*D6111 Implant /abutment retained removable denture for edentulous arch – mandibular
*D6112 Implant /abutment retained removable denture for partially edentulous arch – maxillary
*D6113 Implant /abutment retained 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
*D6120 Implant supported retainer – porcelain fused to titanium and titanium alloys
*D6121 Implant supported retainer for metal FPD – predominantly base alloys
*D6122 Implant supported retainer for metal FPD – noble alloys
*D6123 Implant supported retainer for metal FPD – titanium and titanium alloys
*D6191 Placement of semi-precision abutment – implant body
*D6192 Semi-precision attachment – placement
*D6194 Abutment supported retainer crown for FPD – titanium and titanium alloys
*D6195 Abutment supported retainer – porcelain fused to titanium and titanium alloys
*D6197 Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant
*D7994 Surgical placement: zygomatic implant

Class C Implant Services Notes:

- Implant Services – The implant procedure codes with an asterisk (*) within the implant section 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 or $2,000 for Standard Option if out-of-network. Replacement implant services are covered only 5 years after initial placement of existing implant or appliance to replace missing teeth unless required as a result of an accidental bodily injury and satisfactory evidence is presented showing the implant services could not be made serviceable

Adjunctive general services
D9219 Evaluation for moderate sedation, deep sedation or general anesthesia
D9222 Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof
D9223 Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof
D9224 Administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof
D9225 Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof
D9230 Administration of nitrous oxide
D9239 Administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof
D9243 Administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof

Adjunctive general services - continued on next page

Adjunctive general services (cont.)
D9610 Therapeutic parenteral drug, single administration – *Coverage determined by report*
D9612 Therapeutic parenteral drugs, two or more administrations, different medications – *Coverage determined by report*
D9613 Infiltration of sustained release therapeutic drug, per quadrant
D9930 Treatment of complications (post-surgical) – unusual circumstances, by report – *Coverage determined by report*
D9932 Cleaning and inspection of removable complete denture, maxillary
D9933 Cleaning and inspection of removable complete denture, mandibular
D9934 Cleaning and inspection of removable partial denture, maxillary
D9935 Cleaning and inspection of removable partial denture, mandibular
D9941 Fabrication of athletic mouthguard – *Limited to once per covered person per Calendar Year*
D9943 Occlusal guard adjustment – *Limited to once per year.*
D9944 Occlusal guard – hard appliance, full arch
D9945 Occlusal guard – soft appliance, full arch
D9946 Occlusal guard – hard appliance, partial arch
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*
*D9999 Unspecified adjunctive procedure, by report

Adjunctive general services - continued on next page

Adjunctive general services (cont.)

Class C Adjunctive General Services Limitations and Notes:

- Sedation/Anesthesia/Nitrous Oxide 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, intravenous conscious sedation, and nitrous oxide was provided must be submitted along with a report of why anesthesia/sedation was necessary
- Sedation/Anesthesia/Analgesia will be limited to a maximum of 12 total units per date of service, regardless of the combination of sedation and anesthesia codes used
- D9219 Evaluation for moderate sedation, deep sedation or general anesthesia – *Considered integral to all other oral evaluations or consultations. Only payable when anesthesia is payable*
- D9230 Administration of nitrous oxide – *Not covered if performed in conjunction with D9222 Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof,* D9223 Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof, *D9224 Administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof, D9225 Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof, D9239 Administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof, D9243 Administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof*
- Therapeutic drug injections are not covered if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication for the following codes:
  - D9610 Therapeutic parenteral drug, single administration - Coverage determined by report
  - D9612 Therapeutic parenteral drugs, two or more administrations, different medications – Coverage determined by report
- D9613 Infiltration of sustained release therapeutic drug, per quadrant – *When covered, D9613 Infiltration of sustained release therapeutic drug, per quadrant once per date of service for covered members up to age 22, when submitted with extractions (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 and D7251 Coronectomy – intentional partial tooth removal, impacted teeth only) not to exceed a maximum allowable of $300 per date of service*
- Cleaning and inspection of removable dentures which includes D9932 Cleaning and inspection of removable complete denture, maxillary, D9933 Cleaning and inspection of removable complete denture, mandibular, D9934 Cleaning and inspection of removable partial denture, maxillary and D9935 Cleaning and inspection of removable partial denture, mandibular are limited to once per Calendar Year, not within 6-months of D1110 Prophylaxis – adult. These are considered integral if provided on the same date of service as D1110 Prophylaxis - adult
- Occlusal guards which includes D9944 Occlusal guard – hard appliance, full arch, D9945 Occlusal guard – soft appliance, full arch and D9946 Occlusal guard – hard appliance, partial arch 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. Coverage determined by report
- D9999 Unspecified adjunctive procedure, by report – *The plan allowance will be determined upon review of the report*

Services Not Covered:

- Refer to Section 7 for a list of general exclusions

Current Dental Terminology **© American Dental Association**

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 Class D services.
- There is a lifetime maximum benefit of $3,500 under the High Option and $2,500 for in-network and $1,500 for out-of-network under the Standard Option for Class D covered services.
- The maximum allowable charge does not guarantee that the full lifetime maximum will be paid out on a single treatment.
- 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 and the other limitations described in this plan document.
- The dental plan does not require a pre-determination of benefits. G.E.H.A 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-determination for any extensive treatment. By obtaining a pre-determination, 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.
- In-progress treatment for dependents of retiring TDP enrollees will be covered for the 2027 plan year. This is regardless of any current plan exclusions for care initiated prior to the enrollee's effective date.
- Orthodontic treatment is covered only when necessary to treat a malocclusion. This plan does not provide benefits for procedures performed primarily for cosmetic and or the correction of mild-moderate crowding or spacing.

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:** 50% of plan allowance.
  - **Out-of-Network:** 50% of plan allowance and any difference between our allowance and the billed amount.

Orthodontic services
D0340 2D cephalometric radiographic image – acquisition, measurement and analysis – *Limited to once per lifetime*
D0350 2D oral/facial photographic image obtained intra-orally or extra-orally – *Limited once per lifetime*
D0470 Diagnostic casts – *Limited to once per lifetime in conjunction with an ortho case and/or prior to treatment*
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 the adult 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 Adjunctive orthodontic therapy – removable appliance
D8220 Adjunctive orthodontic therapy – fixed appliance
D8660 Pre-orthodontic treatment examination to monitor growth and development
D8670 Periodic orthodontic treatment visit
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8681 Removable orthodontic retainer adjustment – *Limited to once per lifetime*

Class D Orthodontic Services Limitations and Notes:

- Orthodontic treatment is not covered if the initial placement of the appliance on the teeth was made prior to the current Coverage Effective Date of the covered person. Payment for orthodontic treatment will not be made until the appliance placement date has been submitted to us
- Charges will be considered, subject to other plan conditions, as follows:
  - The total case fee and the maximum allowable charge will be divided by the number of months for the total treatment plan Each resulting portion will be considered to be incurred on a monthly basis until the lifetime maximum is paid, treatment is completed or eligibility ends, whichever comes first
  - The maximum allowable charge does not guarantee that the full lifetime maximum will be paid out on a single treatment
- 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)) – All retention and case-finishing procedures are integral to the total case fee. Observations and adjustments are integral to the payment for retention appliances
- D8681 Removable orthodontic retainer adjustment – Limited to once per lifetime. Only considered when services are rendered by a dentist other than the dentist rendering complete orthodontic treatment

Services Not Covered:

- Refer to Section 7 for a list of general exclusions

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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. We will pay benefits, subject to plan provisions, in an amount equal to the covered percentage for the charges incurred by you.

You are responsible for paying the licensed dentist and for submitting your claims to G.E.H.A. This plan reimburses you for covered services. We do not typically provide or arrange for dental care.

Finding an International Provider

You may visit any international licensed dentist and you will receive in-network benefits for any covered benefits received internationally. G.E.H.A's In-network providers extend to the United States and U.S. 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 G.E.H.A first.

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

G.E.H.A has a dedicated email address for our members outside the United States, GEHA_Dental_Overseas@mygeha.com.

Filing International Claims

For services you receive outside of the United States, you are responsible for paying the dentist and for submitting your claims to G.E.H.A for reimbursement. The dental claim forms can be accessed online at www.geha.com/DentalForms. Mail a completed Dental Claim Form and the itemized bills to G.E.H.A Dental Claims, P. O. Box 21191, Eagan, MN 55121 or submit online to www.geha.com/my-member-portal. We will provide translation and currency conversion services for overseas (foreign) claim services. We will reimburse you in US dollars based on the OANDA currency conversion rate. The conversion rate will be based on the date services were rendered.

Customer Service Website and Phone Numbers

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

International Rates

There is one international region. Use rating area 5 in the rate table to find international 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:

- Plaque control programs.
- Over-the-counter dental products, such as teeth whiteners, toothpaste, dental floss.
- Charges for missed appointments.
- Sealants for teeth other than 1st and 2nd permanent molars.
- Missed or canceled appointments, completion of claim form required by us or forwarding records requested by us.
- 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.
- 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, supplies or treatment furnished by yourself, household members or immediate relatives, such as but not limited to 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 including but not limited to; sterilizing instruments.
- 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 implant services or treatment provided primarily for cosmetic.
- Initial placement of implants in edentulous arch when existing complete denture exists. (i.e. G.E.H.A will not upgrade the denture).
- 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 treatments that are not the least costly alternative that accomplishes a result that meets accepted standards of professional dental care as determined by us.
- Crowns, inlays and onlays performed to restore tooth structure lost due to attrition, erosion or abrasion.
- Any procedure, appliance, restoration or treatment as a result of mail order or online orthodontic services.
- Services or treatment started or performed prior to the effective date of your current 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.
- Oral sedation.
- Precision dentures, characterization or personalization of crowns, dentures or restorations.
- Gold foil restorations.
- Restorations, including veneers, which are placed for cosmetic purposes only.
- Protective restoration.
- Composite resin inlays.
- 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.
- Submitting claim forms.
- Filling out paperwork.
- 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 myofascial 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.
- Diagnosis and/or treatment of Sleep Apnea.
- Services or treatment performed by debarred providers.
- Any services that require review by report will be denied when the report is not included.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

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 G.E.H.A FEHB/PSHB medical plan member, send dental claims to:

G.E.H.A Dental Claims
P.O. Box 21191
Eagan, MN 55121

If you are not a G.E.H.A FEHB/PSHB medical plan member, you must first submit your dental claim to your FEHB/PSHB medical plan, and then submit your dental claim to G.E.H.A, along with the FEHB/PSHB medical plan's explanation of benefits (EOB). If the EOB from your FEHB/PSHB 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 G.E.H.A, along with the other plan's explanation of benefits (EOB).

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 and address of the provider;
- Dates that services or treatment were received;
- Description of each service or treatment;
- Tooth number(s) and tooth surface(s) when applicable;
- Current Dental Terminology (CDT) procedure codes when applicable;
- 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.geha.com/FEDVIPInfo. 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 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 G.E.H.A Dental Claims, P. O. Box 21191, Eagan, MN 55121.

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. You must submit the requested information by December 31 of the year after you receive the service, for benefit determination. If submitted after this date, charges will not be considered for benefit payment. Once we pay benefits, checks are stale dated after 2 years. There is a 3-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:

Step One:

- Ask us in writing to reconsider our initial decision by requesting a formal appeal. You must:
  - Write to us within 6 months from the date of our decision; 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.

Step Two:

- Send your request to us. Here are four ways to submit your formal appeal:
  - Submit by email gehadentalappeals@mygeha.com, or
  - Submit by fax: 866-963-0156, or
  - By mail: G.E.H.A Post Service Appeal, P.O. Box 21324, Eagan, MN 55121, or
  - Submit online by logging in at www.geha.com/FEDVIPInfo and completing the online appeal submission form.
  - Log in to your MyGEHA account – Visit www.geha.com/FEDVIPInfo, click the Sign in or register drop-down in the top-right corner, then will click MyGEHA member portal.
  - Hover over Claims and EOBs drop down on top banner, under Claim Appeals- select Submit an appeal.

- Search for claims you'd like to appeal/inquire about by selecting member from the Select Person drop down. Apply filter and select claim number.
- After selecting the claim, select Appeal this claim. This link will only be visible if the claim has been processed or if the claim is appealable.
- After selecting Appeal this claim, users will get a pop-up box containing information on the process. Select the ineligible code you wish to have reviewed and select continue.
- Enter detailed information in the Claim dispute comments section and upload documents, then select continue.
- Add your contact information, then select continue.
- Review your request summary and select Submit when you're finished.

Step Three:

- 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, 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.

Step Four:

- If you do not agree with our final decision, you may request an independent third party, mutually agreed upon by us and OPM, final appeal 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
  - Include a statement about why you are requesting an independent third-party final appeal 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.
  - Submit your request to us. Here are four ways to submit your formal appeal:
  - Submit by email gehadentalappeals@mygeha.com, or
  - Submit by fax: 866-963-0156, or
  - By mail: G.E.H.A Post Service Appeal, P.O. Box 21324, Eagan, MN 55121, or
  - Submit online by logging in at www.geha.com/FEDVIPInfo and completing the online appeal submission form.
  - Log in to your MyGEHA account – Visit www.geha.com/FEDVIPInfo, click the Sign in or register drop-down in the top-right corner, then will click MyGEHA member portal.
  - Hover over Claims and EOBs drop down on top banner, under Claim Appeals- select Submit an appeal.
  - Search for claims you'd like to appeal/inquire about by selecting member from the Select Person drop down. Apply filter and select claim number.

- After selecting the claim, select Appeal this claim. This link will only be visible if the claim has been processed or if the claim is appealable.
- After selecting Appeal this claim, users will get a pop-up box containing information on the process. Select the ineligible code you wish to have reviewed and select continue.
- Enter detailed information in the Claim dispute comments section and upload documents, then select continue.
- Add your contact information, then select continue.
- Review your request summary and select Submit when you're finished.
- Include a statement about why you are requesting an independent third-party final appeal 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.

Step Five:

- The independent third party will review your final appeal 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 restorations, 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.
Debarred	Services or treatment performed by debarred providers.
Deductible	A deductible is a fixed amount of expenses you must incur for certain covered services before we will pay for covered services. Covered charges credited to the deductible are also counted towards the Plan maximum and limitations.
Enrollee	The Federal employee, annuitant, or TRICARE-eligible individual 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).
In-Progress Treatment	Dental services that initiated in 2026 that will be completed in 2027.
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-Determination	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.
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.
Sponsor	Generally, a sponsor means the individual who is eligible for medical or dental benefits under 10 U.S.C. chapter 55 based on their direct affiliation with the uniformed services (including military members of the National Guard and Reserves).
Subrogation	If G.E.H.A pays benefits for an illness or injury for which you or your dependent are later compensated or reimbursed from another source, you must refund G.E.H.A from any recovery you or your dependent obtain. All G.E.H.A benefit payments in these circumstances are conditional, and remain subject to our contractual benefit limitations, exclusions and maximums.

TEI certifying family member	Under circumstances where a sponsor is not an enrollee, a TEI family member may accept responsibility to self-certify as an enrollee and enroll TEI family members.
TRICARE-eligible individual (TEI) family member	TEI family members include a sponsor's spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in a sponsor's legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.
We/Us	G.E.H.A Connection Dental Federal®.
You	Enrollee or eligible family member.

Non-FEDVIP Benefits & Discounts

Our dental plans go beyond your oral health with these great value-added benefits and discount programs.

G.E.H.A Member Discount Program – **www. geha.com/DiscountProgram**

The G.E.H.A member discount program helps you and your family save on everyday needs while supporting your overall well-being. Members are able to save on nationally recognized brand-name products and services as well as access enhanced discounts on travel, fitness, personal care, groceries, electronics, childcare, senior care and more, all included with your G.E.H.A benefit plan.

Enjoy hundreds of discounts on the services you and your family use most. The G.E.H.A member discount program saves time with one-stop shopping, makes everyday expenses more affordable, and allows you to shop from home or on your mobile device.

Connection Vision® - 877-808-8538 – www. geha.com/Save-Vision

Connection Vision provides eye care to you and your covered family members at low cost and is available at no extra cost to all G.E.H.A Connection Dental Federal members. Connection Vision includes low copays for eye exams and discounts on lenses, frames and contact lenses. Call or go online to find a list of participating locations.

Connection Hearing® - 844-224-2712 – www. geha.com/Hearing-Savings

G.E.H.A members and their families can save 30% to 60% off the average retail price of hearing aids through the Plan's hearing partner. Shop from a selection of more than 100 of the latest hearing aids from the top hearing aid manufacturers in the world. Call to set up an appointment with a provider in your area or go online to learn more.

These benefits are neither offered nor guaranteed under contract with the FEDVIP Program but are made available to all enrollees who become members of G.E.H.A and their eligible family members.

Tools and Resources

FedViser

Need help reviewing G.E.H.A. dental plan options? Find the plan that best fits your lifestyle and understand the extra benefits that G.E.H.A. offers. Here are three easy ways to reach a FedViser Monday-Friday from 8 a.m.-8 p.m. Eastern time:

- Call 1-855-268-1102
- Meet one-on-one with a FedViser at www. geha.com/DentalMeet
- Chat live by visiting www. geha.com

Dental Plan Compare Tool

Need help comparing plans between High Option and Standard Option? No in-network deductibles and no waiting periods. Compare plans at www. geha.com/CompareDental

Website

Our website, G.E.H.A. FEDVIP Dental, has the necessary tools and resources that will help you get the most out of your coverage, including:

- Plan Brochures
- Compare dental plans
- Find Care
- Dental Procedure Pricing Tool
- Talk with a FedViser
- How to enroll in a dental plan

Member Portal

MyG.E.H.A member portal gives you secure, 24/7 access to your benefits with information personalized to you.

- View and print your ID card
- Track or upload claims
- Live Chat: Connect with G.E.H.A customer care by chat, call or secure messaging
- Access plan documents and forms

MyG.E.H.A Member Mobile Application

MyG.E.H.A's mobile application is available 24/7. It's available to download for both iOS and Android mobile phones. The mobile application experience for federal employees, retirees and uniformed service retirees who are members of G.E.H.A dental plans. MyG.E.H.A app, members can easily access secure dental benefit information, including:

- Instant access: Access digital ID card
- Plan details & claims: View plan details on-demand (view or upload claims, balances, including deductibles and out-of-pocket maximums)
- Find Care: Search for in-network dental providers

- Single Sign On: One tap access to important resources so there's no need to login again
- Live Chat: Connect with G.E.H.A customer care by chat, call or secure messaging
- Personalization: See a personalized list of things to do - Stay on top of your health and keep your benefits up to date

G.E.H.A Teledentistry

Connect with 24/7 virtual dental care after hours, over the weekend or on holidays when an office visit isn't possible.

- For more information, visit G.E.H.A Teledentistry

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 800-356-5803, and explain the situation.
- 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);
  - Your child over age 22 (unless they are disabled and incapable of self- support); or
  - For TRICARE Retiree enrollees: Your child over age 21 or age 23 if a full-time student.

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 information 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.gov or call 1-877-888-FEDS (1-877-888-3337), TTY: 711, International: 1-571-730-5942.
- High Option Class A, B, and C Services are subject to an unlimited annual maximum benefit.
- High Option Class C Implant Services are limited to an annual maximum of $2,500 per covered person.
- Standard Option Class A, B, and C Services are subject to a $2,500 annual maximum for in-network, $2,000 Annual Maximum for out-of-network.
- Standard Option out-of-network Services under Class A, B and C are subject to a combined $75 Deductible per person, per calendar year.

High Option Benefits	You Pay	
Benefit Description	**In-Network**	**Out-of-Network**
Class A (Basic) Services – preventive and diagnostic Class A, B, and C Services are subject to an unlimited annual maximum benefit *Out-of-Network: Any difference between the plan allowance and the billed amount	$0	*$0
Class B (Intermediate) Services – includes minor restorative services Class A, B, and C Services are subject to an unlimited annual maximum benefit *Out-of-Network: 20% of the plan allowance and any difference between our allowance and the billed amount	20%	*20%
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services Class A, B, and C Services are subject to an unlimited annual maximum benefit Class C Implant Services are limited to an annual maximum of $2,500 per covered person *Out-of-Network: 50% of the plan allowance and any difference between our allowance and the billed amount	50%	*50%
Class D - Orthodontic Class D Orthodontic Services with a $3,500 Lifetime Maximum *Out-of-Network: 30% of the plan allowance and any difference between our allowance and the billed amount	30%	*30%

Standard Option Benefits	You Pay	
Benefit Description	**In-Network**	**Out-of-Network**
Class A (Basic) Services – preventive and diagnostic Class A, B, and C Services are subject to a $2,500 annual maximum for in-network and $2,000 annual maximum for out-of-network Class A, B and C are subject to a combined $75 Deductible per person, per Calendar Year for out-of-network *Out of network: 25% of the plan allowance and any difference between the plan allowance and the billed amount	$0	*25%
Class B (Intermediate) Services – includes minor restorative services Class A, B, and C Services are subject to a $2,500 annual maximum for in-network and $2,000 annual maximum for out-of-network Class A, B and C are subject to a combined $75 Deductible per person, per Calendar Year for out-of-network *Out of network: 50% of the plan allowance and any difference between the plan allowance and the billed amount	45%	*50%
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services Class A, B, and C Services are subject to a $2,500 annual maximum for in-network and $2,000 annual maximum for out-of-network Class A, B and C are subject to a combined $75 Deductible per person, per Calendar Year for out-of-network *Out of network: 70% of the plan allowance and any difference between the plan allowance and the billed amount	65%	*70%
Class D (Orthodontic) Services - Adults & Children Class D Orthodontic Services with $2,500 Lifetime maximum for in-network and $1,500 Lifetime maximum for out-of-network *Out of network: 50% of the plan allowance and any difference between our allowance and the billed amount	50%	*50%

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Rating 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)								
State	**Zip**	**Rating Region**	**State**	**Zip**	**Rating Region**	**State**	**Zip**	**Rating Region**
AK	Entire State	5	LA	Entire State	2	OH	Rest of State	1
AL	Entire State	1	MA	012	2	OK	Entire State	2
AR	Entire State	1	MA	010-011, 013-027, 055	4	OR	Entire State	3
AZ	850-853, 864	3	MD	205-212, 214, 216-217	4	PA	172-174	4
AZ	Rest of State	2	MD	219	3	PA	180-181, 183	5
CA	900-908, 910-928, 930-931, 933-935, 939-952, 954, 956-959	5	MD	Rest of State	2	PA	189-196	3
CA	Rest of State	4	ME	039-042	4	PA	Rest of State	1
CO	Entire State	4	ME	Rest of State	3	PR	Entire Area	1
CT	060-063	4	MI	480-485	3	RI	Entire State	4
CT	064-069	5	MI	Rest of State	2	SC	Entire State	2
DC	Entire State	4	MN	550-551, 553-555, 563	3	SD	Entire State	2
DE	Entire State	3	MN	Rest of State	2	TN	Entire State	2
FL	329-334, 349	3	MO	Rest of State	2	TX	739, 750-754, 760-762, 770, 772-775, 780-782	2
FL	Rest of State	2	MO	726	1	TX	733, 786-787	3
GA	300-303, 305-306, 311, 399	3	MS	Entire State	1	TX	Rest of State	1
GA	Rest of State	2	MT	Entire State	2	UT	Entire State	2
GU	Entire Area	1	NC	Entire State	2	VA	201, 205, 220-227	4
HI	Entire State	3	ND	Entire State	1	VA	Rest of State	2
IA	Entire State	1	NE	Entire State	1	VI	Entire Area	1
ID	Entire State	2	NH	Entire State	4	VT	Entire State	2
IL	600-609, 613	3	NJ	080-084	3	WA	980-985	5
IL	620, 622	2	NJ	070-079, 085-089	5	WA	986	3
IL	Rest of State	1	NM	Entire State	3	WA	Rest of State	4
IN	460-462, 470, 472-473	2	NV	897	5	WI	540	3
IN	463, 464	3	NV	Rest of State	3	WI	Rest of State	2
IN	Rest of State	1	NY	005, 100-119,124-126	5	WV	254	4
KS	660-662, 666	2	NY	063	4	WV	Rest of State	1
KS	Rest of State	1	NY	Rest of State	1	WY	834	2
KY	410	2	NY	120-123, 128, 140-143	2	WY	Rest of State	1
KY	Rest of State	1	OH	430-433, 437, 440-443, 446-447, 450-455, 459	2	INTL	International	5

High and Standard Rates

Rating Area	High - Bi-Weekly			High - Monthly		
	Self Only	Self Plus One	Self and Family	Self Only	Self Plus One	Self and Family
1	$18.97	$37.92	$56.88	$41.10	$82.16	$123.24
2	$21.32	$42.62	$63.95	$46.19	$92.34	$138.56
3	$23.26	$46.53	$69.79	$50.40	$100.82	$151.21
4	$26.05	$52.08	$78.13	$56.44	$112.84	$169.28
5	$28.23	$56.46	$84.63	$61.17	$122.33	$183.37

Rating Area	Standard - Bi-Weekly			Standard - Monthly		
	Self Only	Self Plus One	Self and Family	Self Only	Self Plus One	Self and Family
1	$10.82	$21.61	$32.41	$23.44	$46.82	$70.22
2	$12.11	$24.22	$36.24	$26.24	$52.48	$78.52
3	$13.27	$26.48	$39.75	$28.75	$57.37	$86.13
4	$14.81	$29.60	$44.39	$32.09	$64.13	$96.18
5	$16.00	$32.00	$48.00	$34.67	$69.33	$104.00