GEHA®

Government Employees Health Association

2024 GEHA PLAN MANUAL FOR DENTAL PROVIDERS

Publication date: January 1, 2024

The 2024 GEHA Plan Manual for Dental Providers is intended solely as a reference guide. For complete information please refer to the applicable GEHA Brochure(s) available online at https://www.geha.com/resource-center/forms-and-documents.

GEHA
Government Employees Health Association

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December 2023

Dear Providers,

We are committed to supporting the provision of quality, comprehensive, equitable and affordable care to all our members. This is only possible by fostering a strong relationship with the provider network that cares for our members. This manual is one way we aim to continue to work collaboratively with you, the provider, to share valuable information about the benefit coverage and guidelines that direct the dental plans we offer to federal employees, federal annuitants, retired military and their families through the Federal Employee Dental and Vision Insurance Program (FEDVIP) and Connection Dental Plus. This Plan Manual is designed as a reference guide for the dental plans we offer.

GEHA offers two FEDVIP Plans, GEHA Connection Dental Federal® High option and GEHA Connection Dental Federal® Standard option. GEHA Connection Dental Plus is available as a supplemental benefit plan outside of the two FEDVIP plan offerings. The Connection Dental Plus plan is a great option for dependents that are no longer eligible for dental coverage in the FEDVIP program. Overage dependents can enroll in Connection Dental Plus until age 26.

GEHA medical plans have limited dental benefits included under the Federal Employee Health Benefit (FEHB) program.

As part of our commitment to caring for our members and caring for each other, GEHA developed this Plan Manual for providers to support a mutually beneficial, transparent relationship between GEHA and the providers who care for our members. We are grateful to have your participation! If you have any questions or concerns about the information contained in this manual, please contact our Customer Care team or reach out to me directly.

Sincerely,
Dr. Patty Steiner
Director, Dental Networks & Plans patty.steiner@geha.com
O: 816.257.3323
GEHA | Connection Dental Network

GEHA
Government Employees Health Association

Section 1: How to contact us

For GEHA plan inquiries and benefit information: You can reach us Monday through Friday from 7 a.m. – 7 p.m. Central time.

Customer care

- **GEHA FEHB:** 800.821.6136
- **GEHA Connection Dental Federal® (FEDVIP):** 877.434.2336
- **GEHA CD Plus:** 800.793.9335
- **Accessibility with TDD:** 800.821.4833

All plans

- **Fax:** 816.257.3241
- **Postal mail:** GEHA, P.O. Box 21542, Eagan, MN 55121

Provider network, plan and participation contact information

- Provider web accounts are only available for Employer Identification Numbers (EIN) registered with GEHA. Please send a W9 to Provider Data Management at fax 816.257.3254 to register your EIN. Providers can use web accounts to view eligibility and claims information for GEHA members.
- Federal Employee Health Benefits program (FEHB Medical plans) utilizes the GEHA Connection Dental Network.
- GEHA Dental plans utilize four networks: GEHA Connection Dental Network, CIGNA Network, Careington Network and DentaMax Network.
    - **GEHA Connection Dental Contact Number:** 800.505.8880
        - Fax: 816.257.4439
        - Hours of operation: 8:00 a.m. - 4:30 p.m.
        - **https://www.connectiondental.com/account/login**
        - Refer to your GEHA Connection Dental Provider Manual for credentialing and contract details
    - Cigna fee schedule: 800.244.6224
    - Careington/DentaMax fee schedule: 800.441.0380 Option #8

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Section 2. Resources and services

Interactive Voice Response (IVR) system

The IVR system is available 24 hours a day, 7 days a week, by calling 800.505.8880 and following the provider validation prompt.

- Fee schedule fax back
- Location effective date
- Initial application status

Provider web portal

The provider web portal may be used for claims search, predetermination search and eligibility.

- Claims search
  - Check your patient's claims status and copies of EOBs. Information available 24-48 hours following the processing date. PDF files available four-five days after the process date.
- Predetermination search
  - Check status of the predetermination. Available 24-48 hours following the processing date. PDF files available four-five days after the process date.
- Eligibility
  - Check your patient's effective date and plan (GEHA FEDVIP Standard or High option)
  - Plan description
  - Eligible (check for active or terminated status)
  - Effective date

How to register for the provider portal

Provider accounts have access to view claims under their registered Tax/EIN number.

To set up a web account, providers should go to **www.geha.com.** Select "Register Now" from the account log-in box at the upper-left of the page, then choose the Provider. Please send a W9 to Provider Data Management at fax 816.257.3254 to register your Tax/EIN number.

Provider web accounts are tied to the Tax ID/FTIN, but each employee needing access should create a separate account. Employee's name listed for the individual username can call for web assistance on the account.

Provider accounts with no activity for a consecutive period of six months will automatically become inactivated.

Section 3. Member eligibility verification

Check member eligibility

Web account: Check the member eligibility and effective date through the self-service provider web account. See Section 2 for information about how to register or call us.

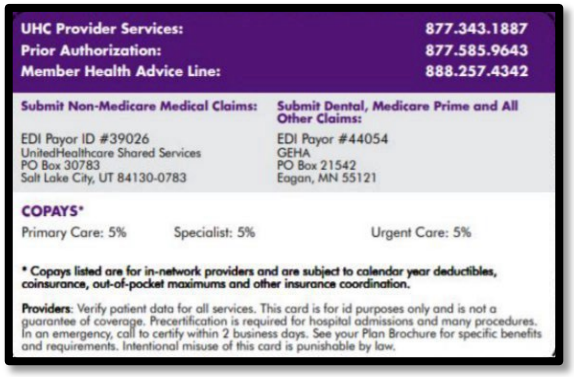
Contact us for GEHA plan inquiries and benefit information: You can reach us Monday through Friday from 7 a.m. – 7 p.m. Central time.

Customer care

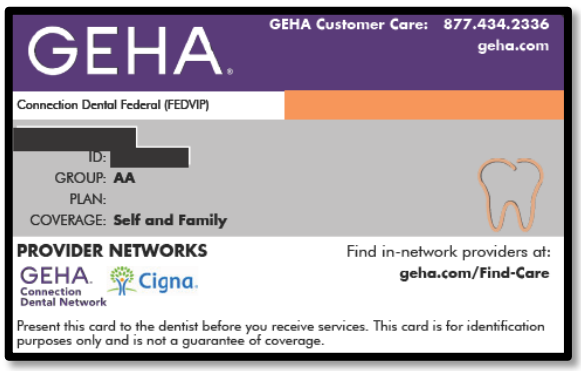
- **GEHA FEHB:** 800.821.6136
- **GEHA Connection Dental Federal® (FEDVIP):** 877.434.2336
- **GEHA CD Plus:** 800.793.9335
- **TDD assistance:** 800.821.4833

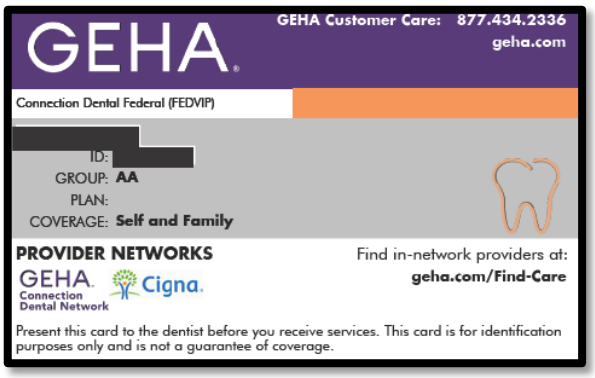
Identification card examples: Please see your patient's member ID card for details.

FEHB

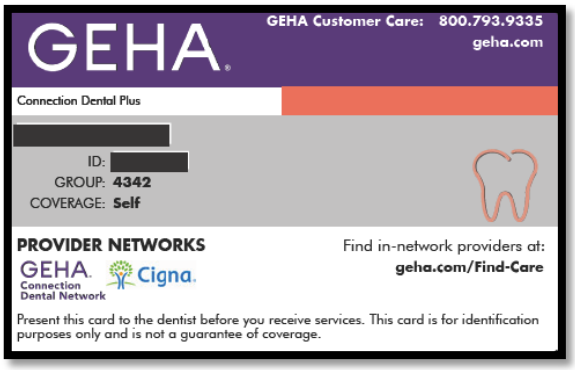


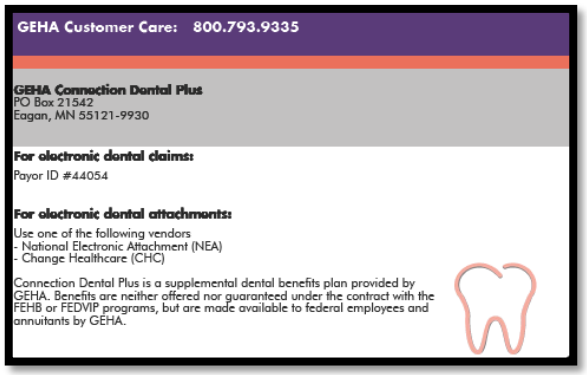
(FEDVIP) GEHA Connection Dental Federal® High & Standard option





CD Plus





Section 4. How to submit a claim

Electronic submission and electronic attachments

- Submit electronically: GEHA Payor ID 44054
- GEHA Connection Dental Federal® (FEDVIP) Group: AA
- CD Plus Group: 4342

NEA number or CHC number: Dental X-rays, lab reports, EOBs, narratives, operative reports, clinical notes, periodontal charts and any other document required to process a dental claim can be submitted via NEA or CHC.

- NEA FastAttach: Include NEA Attachment ID in remarks (box 35) of Dental Claim form. If you are new to NEA, take advantage of our GEHA offer for free registration and one month of free service. *This is a $200 savings off the normal registration price. **Click https://reg.nea-fast.com/ to register and enter promotion code GEHARZ1M.**
- CHC Dental Connect (Change Healthcare): Include CHC Attachment ID in remarks (box of Dental Claim form.

How to submit a paper claim

Please ensure you have GEHA's current claims submission address. A delay in processing may occur if not sent to the below address.

GEHA
P.O. Box 21542
Eagan, MN 55121

Title documents re: action needed for claims submissions

Please include a title describing the action needed for your claim submission(s) and documents. For example, "Dental Claim Submission" to describe that you are submitting a dental claim. For example, title a resubmission with additional information as a "Resubmission of Dental Claim with Additional Information" or "Dental Claim Appeal" if it is an appeal.

How to submit a fax claim

Fax: 816.257.3241

When fax is not appropriate: Faxed X-rays and/or images will not be accepted because the fax process can distort/reduce the image quality.

Fax is appropriate and best for responses to requested information such as other carrier EOBs, patient records, etc. There are other methods to submit claims (mailing paper forms and electronic submissions). Please include a fax cover sheet with the fax content.

Please include the following on a fax cover sheet:

ATTN: Dental Claims

RE: (i.e., Dental Claim Submission, Resubmission with Additional Information, Corrected Primary EOB, Appeal, etc.)

Member ID:

Patient Name:

Claim Number:

Date of Service:

Helpful tips for submitting dental claims to GEHA

1. When GEHA members have dental claims that will be reimbursed by GEHA medical and dental plans, please only send one claim to GEHA for the services rendered.

    - We will make sure both medical and dental plans process the claim.
    - When a provider sends the same claim to both GEHA medical and GEHA dental plans, this may add to our backlog. Duplication may cause a delay in processing.

2. When you submit a claim electronically, it takes time for the submission to be populated in our claims processing system. If your claim does not appear in three business days, then please let us know.

3. Sending duplicate claims may delay processing due to the need to remove duplicates. This can add time to claims processing.

4. For further information about dental coding guidance, please refer to details regarding service descriptions by referring to your copy of the 2024 Current Dental Terminology © American Dental Association.

Pre-determination

- The dental plan does not require a pre-determination of benefits. GEHA will respond to a request to pre-determine services with an estimate of covered service, which is not a guarantee of payment since future changes, such as changes in members enrollment or eligibility under the dental plan, may affect benefits. We encourage members to ask their provider to request a pre-determination for any extensive treatment. By obtaining a pre-determination, members and their 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 members in making an informed decision on how to proceed with treatment and can help protect members 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.

What to submit

- Completed claim form
  - Diagnosis
  - Remarks: Please note symptoms
- Images
  - Radiographs
  - Intraoral photos (etc.)
  - Digital impressions
- Documentation
  - Any applicable narrative
  - Tooth number
  - Recession measurements
  - Attached keratinized gingiva measurement for each tooth
  - Pocket depth measurements
  - Frenum
  - Documentation of active recession
  - Other contributing factors

Common clinical guideline questions
For connective tissue graphs, for example D4273 and D4283 (next tooth), please remember to chart attachment levels for mucogingival defects (MGD). Chart the lack of attached gingival tissue. When there is zero attachment, please document by charting findings. Diagnosis, symptoms, clinical notes, charting of mucogingival junction and the resulting attached gingiva, including the probe depth at the site of the defect, clinical attachment level and include recession.

Helpful tip: Please document the periodontal procedures with images (radiographs and photos if available), clinical notes with level of attached gingiva (mucogingival junction, probing, CAL and recession), diagnosis and symptoms.

Note: GEHA does not cover treatment performed for cosmetic/esthetic reasons.

Claims or authorizations submitted that demonstrate a Class I occlusal relationship are not considered cosmetic in nature and meet the guidelines for coverage when one or more of the following is present and planned for correction: Severe crowding or spacing (5mm or greater of anterior crowding or spacing is present and evident in the photos) Deep bite (>50% of mandibular anterior teeth are covered with or without severe wear 30% or greater with evidence of anterior chipping or wear) cross bite (anterior or posterior).

Section 5. Payment

Due to Phase III of the Affordable Health Care Act, effective January 1, 2014, GEHA offers three methods of payment available to providers virtual credit card (VCC), electronic funds transmission (ETF) and paper check.

Virtual Credit Card (VCC)
Provides payment through a one-time credit card number.

Provider payments default to VCC

- Providers may opt out of VCC payments through Change Healthcare (formerly known as Emdeon). You must opt out every year.

ECHO (Quick Remit) contact information

- **Telephone:** 888.680.4079
- **Payment manager:** www.echovcards.com

ECHO (Quick Remit) handles VCC-related issues and questions, including:

- Opting out
- Posting the VCC
- Refunds
- Forgeries

Electronic Funds Transmission (EFT)
Electronic deposits payment to the provider's bank account.

To enroll in EFT, please visit Change Healthcare's website to complete your enrollment https://dental.changehealthcare.com/ or call 866.777.0713.

Each provider under a tax ID/FTIN has their own GEHA provider ID. Each provider ID needs to be opted-out of virtual credit card payments to receive EFT payments or paper checks. Please contact GEHA if you need the provider ID.

Paper check

Providers must disenroll from the VCC program to receive paper checks. To opt out of VCC, please contact ECHO Remit at 888.680.4079.

If we overpay

We will make diligent efforts to recover benefit payments we made in error. We may reduce subsequent benefit payments to offset overpayments. Federal laws supersede state laws regarding our right to recovery of overpayments.

Claim selection and professional claim review

GEHA screens and selects dental claims for review. Once a claim is selected for professional review, a licensed dentist trained in clinical claim review determines if the documentation submitted supports coverage under the plan based on clinical guidelines. Dental benefits are not designed to cover every possible treatment scenario. Plans offer a negotiated set of benefits for a set premium. GEHA aims to cover services most often needed by the largest subset of our members and those services that contribute to overall health and wellbeing. A claim denial is a determination of benefits based on the plan guidelines and should not be interpreted as an evaluation of a treatment plan.

Clinical guidelines for review

Our claims review process aims to ensure the care provided to our members meets professionally recognized standards and clinical guidelines for coverage under the plan.

“By report”

If a procedure is covered “by report,” please submit according to the ADA CDT manual recommendation. “By report” requires a narrative including a clear description of the procedure performed and the reason for treatment (diagnosis and treatment needed). Throughout the Plan Benefit (Part I, Part II and Part III) we describe covered services for each plan. The term “by report” is described in the service details if needed.

Section 6. Coordination of benefits

FEHB first payor

When a member visits a provider who participates with both a FEHB plan and a FEDVIP plan, the FEHB 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 plan and the provider.

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

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

It is important for members to bring the FEDVIP and FEHB identification cards to every dental appointment because most FEHB plans offer some level of dental benefits separate from FEDVIP coverage.

Members presenting both identification cards may help providers to submit claims accurately (where the FEHB plan is first payor) to ensure that members receive the maximum allowable benefit under each program.

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

FEDVIP GEHA High option member with FEHB coverage: FEHB plan is always primary payor. GEHA Connection Dental Federal High option plan is secondary.

Charges by an In-Network Provider
Extraction of tooth: $150.00
Primary FEHB allowable: $123.00
Primary FEHB 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 plan. The provider can collect up to their billed charge.

FEDVIP GEHA High option member with FEHB coverage. FEHB plan is always primary payor. GEHA Connection Dental Federal High option plan is secondary Charges by Out-of-Network Provider

Extraction of tooth: $150.00
Primary FEHB 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 between non-FEHB / FEHB / FEDVIP

We determine which non-FEHB coverage is primary according to National Association of Insurance Commissioners' (NAIC) guidelines. When a member visits a provider who participates with both an FEHB plan and a FEDVIP plan, refer to the "FEHB First Payor" section. We will coordinate benefit payments with the payment of benefits under other group health benefits coverage a member may have and the payment of dental costs under no-fault insurance that pays benefits without regard to fault.

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

We recommend that members verify/identify health insurance plan(s) annually or at the time of service. Members may call or mail other coverage information or report it online at www.geha.com/DentalCOB.

When members 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 a member's FEHB medical plan before we calculate benefits payable by us. In addition to benefits payable by the FEHB medical plan, if members or covered dependents have other dental coverage, members must tell GEHA. When we are secondary or tertiary (third) payor, our payment will be the lesser of the following:

- GEHA'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.

If the primary payor requires a pre-determination or requires that members use designated facilities for benefits to be approved, it is the member's responsibility to comply with these requirements. In addition, members must file the claim with their primary payor within the required time period. If members 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 members had followed their requirements.

CD Plus coordination of benefits information

Connection Dental Plus supplements other dental coverage members may have so it pays after other dental benefits. If members have other coverage, the member's other carrier's explanation of benefits is necessary before Connection Dental Plus benefits can be paid. If a covered person is also covered under other dental coverage, we pay the lesser of CD Plus benefits in full or a reduced amount that when added to the benefits payable by the other coverage will not exceed 100% of the covered expenses.

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

Example: Primary carrier(s') payment(s), GEHA is secondary or tertiary in-network

Billed amount	$165.00
GEHA's allowable	$139.00 ($165 - $26 difference)
Primary carrier's payment	$23.00
GEHA's regular benefit	$111.20 ($139 x 80%)
GEHA's payment	$111.20
Patient responsibility	$4.80

Members are not responsible for the $26.00 difference between the charge and the covered expense when members use an in-network dentist. The dentist cannot bill members for this amount.

Example: Primary carrier(s') payment(s), GEHA is secondary or tertiary out-of-network

Billed amount	$31.00
GEHA's allowable	$29.00 ($31 - $2 difference)
Primary carrier's payment	$8.00
GEHA's regular benefit	$29.00 ($29 x 100%)
GEHA's payment	$21.00
Patient responsibility	$2.00

Members are responsible for the $2.00 difference between the charge and the covered expense, when members use an out-of-network dentist. The dentist can bill the member for the difference.

If the member's primary payor requires a pre-determination or requires that members use designated facilities for benefits to be approved, it is the member's responsibility to comply with these requirements. In addition, file the claim with the member's primary payor within the required time period. If the member or their provider fails to comply with any of these requirements and the primary payor denies benefits, GEHA CD Plus will pay secondary benefits based on an estimate of what the primary carrier would have paid if the member followed their requirements.

CD Plus "other dental coverage"

"Other dental coverage" means any dental plan, contract or other means of paying the cost of dental care, including but not limited to:

- Group or blanket coverage; including dental maintenance organizations.
- Any hospital, medical or dental service plan for prepaid group coverage.
- Labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans and professional association plans.
- Any other employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended.
- Government programs, including compulsory no-fault automobile coverage and Medicare, unless coordinating benefits with these types of programs is prohibited by law.
- Plans in the Federal Employees Health Benefits program (FEHB).
- Plans in the Federal Employees Dental and Vision Insurance Program (FEDVIP).

When a plan provides services directly, the reasonable cash value of each service is deemed to be both an allowable expense and a benefit paid.

Section 7. Covered dental benefits by plan

Part I: FEHB covered services summary

Plan: FEHB Dental

- GEHA FEHB High option: Limited dental benefit and Accidental injury benefit
- GEHA FEHB Standard option: Limited dental benefit and Accidental injury benefit
- GEHA HDHP: Limited dental benefit and Accidental injury benefit
- GEHA Elevate: Accidental injury benefit only
- GEHA Elevate Plus: Accidental injury benefit only

FEHB High option

Important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If members are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, the member's FEHB plan will be First/Primary payor of any Benefit payments and the member's FEDVIP plan is secondary to the member's FEHB plan.
- The deductible applies for the Accidental injury benefits (described below).
    - High Option, the calendar year deductible is $350 Self Only ($700 if enrollment is Self Plus One or Self and Family).
    - High Option, the coinsurance is 10% of the plan allowance in-network and 25% of the Plan allowance out-of-network plus any difference between our allowance and the billed amount.
- There is no calendar year deductible for the Limited dental benefits (listed below).

Note: Hospitalization for dental procedures is covered only when a non-dental physical impairment exists, which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure.

FEHB High option: Accidental injury benefit

Restorative services and supplies necessary to promptly repair sound natural teeth are covered under the plan when the need for these services resulted from an accidental injury. The repair of accidental injury to sound natural teeth includes but is not limited to expenses for X-rays, drugs, crowns, bridgework, inlays and dentures. We do not cover oral implants and transplants.

Masticating (biting or chewing) incidents are not considered to be accidental injuries. Accidental dental injury is covered at 100% for charges incurred within 72 hours of an accident under the High option. Services incurred after 72 hours are paid at regular plan benefits.

FEHB High option: Limited dental benefits

Benefits are limited to two visits per calendar year. The plan will pay $22 per visit, for a total of $44 paid per person per year. Visits may include any combination of:

- Exams
- Prophylaxis (cleanings)
- Fluoride (no age limit)
- X-rays (no frequency limit)
- In addition:
    - One surface restoration: Plan pays $21 per tooth
    - Two or more surface restorations: Plan pays $28 per tooth
    - Simple extractions: Plan pays $21 per tooth

FEHB Standard option

Important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations and exclusions in this member's brochure and are payable only when we determine they are medically necessary.
- If members are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental plan, the member's FEHB plan will be First/Primary payor of any Benefit payments and the member's FEDVIP plan is secondary to the member's FEHB plan.
- The following applies for the Accidental injury benefits (described below).
    - Standard Option, the calendar year deductible is $350 Self Only ($700 if enrollment is Self Plus One or Self and Family) if you use in-network providers.
    - Standard Option, the coinsurance is 15% of the plan allowance in-network.
    - Standard Option, the calendar year deductible is $700 Self Only ($1,400 if enrollment is Self Plus One or Self and Family) if you use out-of-network providers.
    - Standard Option, the coinsurance is 35% of the plan allowance and any difference between our allowance and the billed amount.
- There is no calendar year deductible for the Limited dental benefits (listed below).

Note: Hospitalization for dental procedures is covered only when a non-dental physical impairment exists, which makes hospitalization necessary to safeguard the health of the patient. The dental procedure is not covered.

FEHB Standard option: Accidental injury benefit

Restorative services and supplies necessary to promptly repair sound natural teeth are covered when these services resulted from an accidental injury. The repair of accidental injury to sound natural teeth includes but is not limited to expenses for X-rays, drugs, crowns, bridgework, inlays and dentures. We do not cover oral implants and transplants. Masticating (biting or chewing) incidents are not considered to be accidental injuries.

FEHB Standard option: Limited dental benefit

Benefits are limited to two visits per calendar year:

- Exams
- Prophylaxis (cleanings)
- Fluoride (no age limit)
- X-rays (no frequency limit)
- In addition:
    - One surface restoration: Plan pays $21 per tooth
    - Two or more surface restorations: Plan pays $28 per tooth
    - Simple extractions: Plan pays $21 per tooth

Exams, prophy and fluoride are paid at 50% of GEHA's allowable amount. X-rays (any type) are paid at 50%, for a maximum of $75 paid per person per calendar year.

HDHP

Important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations and exclusions in the brochure and are payable only when we determine they are medically necessary.
- If members are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental plan, their FEHB plan will be First/Primary payor of any Benefit payments and their FEDVIP plan is secondary to the FEHB plan.
- Benefits in this section are covered in full if rendered by preferred providers. Preventive services from a non-preferred provider would be applied to the calendar year deductible and payable under traditional medical coverage benefits.
- Preventive care for children is covered in full from preferred and non-preferred providers.
- The calendar year deductible does apply to Accidental injury benefits.
    - If members use an in-network provider, the benefit is subject to the calendar year deductible of $1,600 for Self Only, ($3,200 for Self Plus One or Self and Family) and 5% co-insurance.
    - If members use an out-of-network provider, the benefit is subject to the calendar year deductible of $3,200 for Self Only ($6,400 for Self Plus One or Self and Family) and 5% co-insurance, plus the difference between the billed amount and the plan allowance.

Be sure to read the section on costs for covered services for valuable information about how cost sharing works. Also read the section about coordinating benefits with other coverage or if members are age 65 and over. If Medicare is the member's primary payor, GEHA will provide secondary benefits for covered charges. The high deductible health plan deductible and coinsurance is not waived for Medicare members.

HDHP: Limited dental benefit

Benefits are limited to two visits per calendar year:

- Exams
- Prophylaxis (cleanings)
- Fluoride (no age limit)
- X-rays (no frequency limit)
- In addition:
    - One surface restoration: Plan pays $21 per tooth
    - Two or more surface restorations: Plan pays $28 per tooth
    - Simple extractions: Plan pays $21 per tooth

Exams, prophy and fluoride are paid at 100% of GEHA's allowable amount. X-rays (any type) are paid at 100%, for a maximum of $150 paid per person per calendar year.

HDHP: Accidental injury benefit

This provision applies to dental care required as a result of accidental injury to sound natural teeth.

- Masticating (chewing) incidents are not considered to be accidental injuries.

GEHA Elevate and GEHA Elevate Plus: Accidental injury benefits only

Important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations and exclusions and are payable only when determined to be medically necessary.
- If members are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental plan, their FEHB plan will be First/Primary payor of any Benefit payments and their FEDVIP plan is secondary to the FEHB plan.
- Under the Elevate Plus option, the calendar year deductible is $200 Self Only ($400 if enrollment is Self Plus One or Self and Family) for in-network providers. The Elevate Plus Option does not provide out-of-network benefits except in cases of emergency.
- Under the Elevate option, the calendar year deductible is $500 Self Only ($1,000 if enrollment is Self Plus One or Self and Family) for in-network providers. If members use an out-of-network provider, the calendar year deductible is $1,000 Self Only ($2,000 if enrollment is Self Plus One or Self and Family).

Note: Hospitalization for dental procedures is covered only when a non-dental physical impairment exists, which makes hospitalization necessary to safeguard the health of the patient. The dental procedures are not covered. Services are paid at regular medical Plan benefits. We cover restorative services and supplies necessary to promptly repair sound natural teeth. The need for these services must result from an accidental injury. The repair of accidental injury to sound natural teeth includes but is not limited to expenses for X-rays, drugs, crowns, bridgework, inlays and dentures. X-rays and/or treatment records may be requested in order to determine benefit coverage.

Part II: GEHA Connection Dental Federal® (FEDVIP)

Plans

- GEHA Connection Dental Federal® (FEDVIP) High option dental
- GEHA Connection Dental Federal® (FEDVIP) Standard option dental

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).
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How we have changed for 2024

Changes to High and Standard Options:

- We added procedure code D2929 Prefabricated porcelain/ceramic crown - primary tooth (limited to one per patient, per tooth, per lifetime for Covered Persons under 15 years of age.)
- We expanded coverage for procedure code D9230 (Inhalation of nitrous oxide/analgesia, anxiolysis) to members of all ages when medically and dentally necessary and performed with covered services.

Deadline for filing a claim

Submit all documents for the member's claims as soon as possible. We may, at our option, require supporting documentation such as clinical notes, charts, radiographic images or a narrative.

Class A: Basic (FEDVIP covered 100% High in-network, High out-of-network, Standard in-network. 75% Standard out-of-network. Benefits are based on plan allowance.)

Diagnostic and treatment services

Oral evaluations (D0120, D0145, D0150, D0180) are limited to a maximum of two times per calendar year.

D0120 Periodic oral evaluation.

D0140 Limited oral evaluation, problem focused*: One limited oral evaluation, problem- focused (D0140) allowed per patient per dentist in a 12 consecutive month period. A limited oral evaluation will be considered integral when provided on the same date of service by the same dentist as any other oral evaluation.*

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

D0150 Comprehensive oral evaluation.

D0180 Comprehensive periodontal evaluation.

D0210 Intraoral, comprehensive series of radiographic images: *Full mouth radiographic images and panoramic radiographic images are limited to a combined maximum of once every three calendar years.*

D0220 Intraoral, periapical: First radiographic image.

D0230 Intraoral, periapical: Each additional radiographic image.

Intraoral occlusal, extra-oral 2D and extra-oral posterior X-rays: Limited to a combined maximum of four per 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.

Bitewing radiographic images: *Limited to twice per calendar year for children aged 22 and*

younger and once per calendar year for adults 23 and older. This includes D0270, D0272, D0273, D0274 and D0277.
D0270 Bitewing: Single radiographic image.
D0272 Bitewings: Two radiographic images.
D0273 Bitewings: Three radiographic images.
D0274 Bitewings: four radiographic images.
D0277 Vertical bitewings: Seven to eight radiographic images.
D0330 Panoramic radiographic image: *Full mouth radiographic images and panoramic radiographic images are limited to a combined maximum of once every three calendar years.*
D0425 Caries susceptibility tests.

Preventive services

D1110 Prophylaxis, adult: *If enrolled in Standard option, limited to twice per calendar year. If enrolled in the High option, limited to three per calendar year.*
D1120 Prophylaxis, child: *Limited to twice per calendar year.*
Topical application of fluoride is limited to covered persons under age 22 twice per calendar year.
D1206 Topical application of fluoride varnish.
D1208 Topical application of fluoride, excluding varnish.
Sealants are limited to covered persons under age 18 on unrestored permanent molars only and are limited to one sealant per tooth every three calendar years, which includes D1351 and D1352.
D1351 Sealant, per tooth.
D1352 Preventive resin restoration in a moderate to high caries risk patient, permanent tooth.
D1353 Sealant repair, per tooth*: Limited to once per tooth, per lifetime.*
D1354 Application of caries arresting medicament, per tooth, per lifetime: Limited to children under age nine.
Space maintainers are limited to initial appliance, no more than one per tooth, which includes D1510, D1516, D1517, D1520, D1526, D1527 and D1575, for non-orthodontic treatment of prematurely lost teeth in children under age 19.
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 and D1553.*
D1552 Re-cement or re-bond bilateral space maintainer, mandibular*: Limited twice per calendar year combined with D1551 and D1553.*
D1553 Re-cement or re-bond unilateral space maintainer, per quadrant*: Limited twice per calendar year combined with D1551 and D1552.*
D1575 Distal shoe space maintainer, fixed, unilateral, per quadrant.

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.

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Not covered

- Plaque control programs
- Oral hygiene instruction
- Dietary instructions
- Over-the-counter dental products, such as teeth whiteners, toothpaste, dental floss
- Any exclusions or limitations listed under Section 7 of this plan document
- Charges for missed appointments
- Filling out paperwork
- Submitting claim forms
- Sterilizing instruments

Class B: Intermediate (FEDVIP covered 80% High in-network, High out-of-network. 55% Standard in-network. 50% Standard out-of-network. Benefits are based on plan allowance.)

Important things providers should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in the 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 B and C are subject to a combined $25 deductible per person, per calendar year. The maximum deductible for family coverage is $75.
- 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.
- 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 members or the member's dental provider should choose this treatment or service, we will allow the lower cost alternative benefit unless evidence is submitted with the claim 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.
- The dental plan does not require a pre-determination of benefits. GEHA will respond to a request to pre-determine services with an estimate of covered service, which is not a

guarantee of payment since future changes such as changes in enrollment or eligibility under the dental plan may affect benefits. We encourage members to ask providers to request a pre-determination for any extensive treatment. By obtaining a pre-determination, members and their 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 members in making an informed decision on how to proceed with treatment and can help protect members 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 and supporting materials.
- In-progress treatment for dependents of retiring TRICARE Dental Program (TDP) enrollees will be covered for the 2024 plan year. This is regardless of any current plan exclusions for care initiated prior to the enrollee's effective date.

Minor restorative services

Restorations are limited to one restoration per tooth surface every two calendar years.

D2140 Amalgam, one surface, primary or permanent.
D2150 Amalgam, two surfaces, primary or permanent.
D2160 Amalgam, three surfaces, primary or permanent.
D2161 Amalgam, four or more surfaces, primary or permanent.
D2330 Resin-based composite, one surface, anterior.
D2331 Resin-based composite, two surfaces, anterior.
D2332 Resin-based composite, three surfaces, anterior.
D2335 Resin-based composite, four or more surfaces, anterior.
D2390 Resin-based composite crown, anterior: *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, veneer: *Limited to once per six-month period if more than 12-months from initial placement.*
D2915 Re-cement cast or prefab post and core: *Limited to once per tooth, per lifetime.*
D2920 Re-cement or re-bond crown: Limited to once per six-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 person under 15 years of age.*
D2931 Prefabricated stainless steel crown, permanent tooth*: Limited to one per patient, per tooth, per lifetime for covered person under 15 years of age.*
D2951 Pin retention, per tooth, in addition to restoration.

Not covered

- *Restorations, including veneers, which are placed for cosmetic purposes only.*
- *Gold foil restorations.*
- *Any exclusions or limitations*

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*: 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 six and cuspids up to age 11 and limited to once per tooth per lifetime.*
D3240 Pulpal therapy, resorbable filling, posterior, primary tooth excluding final restoration, incomplete endodontic treatment when members discontinue treatment: *Limited to primary molars for children up to age 11 and limited to once per tooth per lifetime.*
D3921 Decoronation or submergence of an erupted tooth.

Periodontal services

Periodontal scaling and root planing are limited to once per quadrant every two calendar years and are not covered if done within 24 months of periodontal surgical procedures in the same quadrant.

D4341 Periodontal scaling and root planning, four or more teeth per quadrant.
D4342 Periodontal scaling and root planning, 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 two calendar years. This service replaces a routine prophylaxis for the calendar year in which it was performed.*
D4381 Localized delivery of antimicrobial agents: 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.*
D4910 Periodontal maintenance*: 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.*

Prosthodontic services

Adjustment or repair to denture or partial denture is limited to two per calendar year, at least six months after delivery of appliance.

D5410 Adjust complete denture, maxillary.
D5411 Adjust complete denture, mandibular.
D5421 Adjust partial denture, maxillary.
D5422 Adjust partial denture, mandibular.

D5511 Repair broken complete denture base, mandibular.

D5512 Repair broken complete denture base, maxillary.
D5520 Replace missing or broken teeth, complete denture, each 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 broken teeth, per tooth.
D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture, per tooth.
Replacement of all teeth and acrylic on cast metal framework is limited to once every five calendar years.
D5670 Replace all teeth and acrylic on cast metal framework, maxillary.
D5671 Replace all teeth and acrylic on cast metal framework, mandibular.
Tissue conditioning, rebase and reline of dentures is limited to a maximum of once every three calendar years after six months of initial placement.
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.
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 or bridge: *Limited to one per calendar year, after six months of initial placement.*
D6980 Fixed partial denture repair: *Coverage determined by report.*

Oral Surgery

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.

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 reimplantation 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 – per quadrant
D7311 Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions – per quadrant
D7321 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess – intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7971 Excision of pericoronal gingiva
*D7999 Unspecified oral surgery procedure, by report. - *Coverage determined by report. The plan allowance will be determined upon review of the report.*

Class C: Major (FEDVIP covered 50% High in-network, 50% High out-of-network, 35% Standard in-network, 30% Standard out-of-network. Benefits are based on plan allowance.)

Important things providers should keep in mind about these benefits:

- All benefits are subject to the definitions, limitations and exclusions of the plan 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 B and C are subject to a combined $25 deductible per person, per calendar year. The maximum deductible for family coverage is $75.

- 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 five-year limitation.
- Covered services shall include only those services specifically listed. 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 members or their dental practitioner should choose this treatment or service, we will allow the lower cost alternative benefit unless evidence is submitted with the bill to explain why the less expensive treatment could not be done.
- Covered services are limited to the maximum allowable charge as determined by us and are subject to alternative benefit, coinsurance, maximum benefit limits, waiting period and the other limitations described in this plan document.
- The dental plan does not require a pre-determination of benefits. GEHA will respond to a request to pre-determine services with an estimate of covered service, which is not a guarantee of payment since future changes such as changes in member enrollment or eligibility under the dental plan may affect benefits. We encourage members to ask providers to request a pre-determination for any extensive treatment. By obtaining a pre-determination, patients and the 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 patients in making an informed decision on how to proceed with treatment and can help protect patients 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 five years after teeth were replaced previously and only if prior prosthesis cannot be made serviceable.
- In-progress treatment for dependents of retiring TRICARE Dental Program (TDP) enrollees will be covered for the 2024 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 five-year replacement rule.

Major restorative services

D0160 Detailed and extensive oral evaluation, problem focused, by report: Limited to once per covered person per dentist, per lifetime.

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 a direct restoration.

*D2510 Inlay, metallic, one surface.

*D2520 Inlay, metallic, two surfaces.
*D2530 Inlay, metallic, three 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, ¾ 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 predominately base metal.
*D2752 Crown, porcelain fused to noble metal.
*D2753 Crown, porcelain fused to titanium and titanium alloys.
*D2780 Crown, ¾ cast high noble metal.
D2781 Crown, ¾ cast predominately base metal.
*D2782 Crown, ¾ cast noble metal.
*D2783 Crown, ¾ porcelain/ceramic, for posterior teeth only.
*D2790 Crown, full cast high noble metal.
D2791 Crown, full cast predominately base metal.
*D2792 Crown, full cast noble metal.
*D2794 Crown, titanium and titanium alloys.
D2950 Core buildup, including any pins: Covered only when there is evidence presented showing insufficient retention for a crown.
Posts are only covered when provided as part of a buildup for a crown. When performed as an independent procedure, the placement of a post is not covered.
*D2952 Cast post and core in addition to crown.
*D2953 Each additional cast post, same tooth.
D2954 Prefabricated post and core, in addition to crown.
*D2957 Each additional prefabricated post, same tooth.
D2980 Crown repair: Coverage determined by report.
D2981 Inlay repair necessitated by restorative material failure: Coverage determined by report.
D2982 Onlay repair: Coverage determined by report.
D2983 Veneer repair necessitated by restorative material failure: Coverage determined by report.
D2990 Resin infiltration of incipient smooth surface lesions.

Not covered

- *Gold foil restorations.*
- *Protective restoration.*
- *Restorations for cosmetic purposes only.*
- *Composite resin inlays.*

- *Any exclusions or limitations.*

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Endodontic services

D3310 Anterior root canal, 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.
Retreatment of root canal is covered only after 12 months from the prior root canal therapy.
D3346 Retreatment of previous root canal therapy, anterior.
D3347 Retreatment of previous root canal therapy, 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 (apical closure/calcific repair of perforations, root resorption, etc.): *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 surgery, anterior: *Limited to once per tooth, per lifetime.*
D3421 Apicoectomy surgery, premolar, first root: *Limited to once per tooth, per lifetime.*
D3425 Apicoectomy surgery, molar, first root*: Limited to once per tooth, per lifetime.*
D3426 Apicoectomy surgery, each additional root: *Limited to two 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.
D3920 Hemisection (including any root removal), not including root canal therapy.

Periodontal services

Gingivectomy, gingivoplasty, gingival flap procedure and osseous surgery are limited to once per quadrant every two calendar years and are not covered when treating implant and edentulous areas.

D4210 Gingivectomy or gingivoplasty, four or more contiguous teeth or tooth bounded spaces, per quadrant.
D4211 Gingivectomy or gingivoplasty, one to three teeth, per quadrant.
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth:

Limited to once per tooth every two calendar years with restorative procedure.
D4240 Gingival flap procedure, including root planing, four or more contiguous teeth or bounded teeth spaces per quadrant.
D4241 Gingival flap procedure, including root planning, one to three teeth 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.
Tissue graft procedures are not covered when treating implants or in edentulous areas.
D4270 Pedicle soft tissue graft procedure: *Not covered when treating implants or in edentulous areas. Grafts on additional contiguous teeth are payable as secondary procedures. Charges for guided tissue regeneration and use of collagen are considered components of this procedure.*
D4273 Autogenous connective tissue graft procedures, including donor and recipient surgical sites, first tooth: *Not covered when treating implants or in edentulous areas.*
D4275 Non-autogenous connective tissue graft, including recipient site and donor material, first tooth: *Not covered when treating implants or in edentulous areas.*
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: *Not covered when treating implants or in edentulous areas.*
D4278 Free soft tissue graft procedure, including recipient and donor surgical sites, each additional contiguous tooth: *Not covered when treating implants or in edentulous areas.*
D4283 Autogenous connective tissue graft procedure, including donor and recipient surgical sites, each additional contiguous tooth: *Not covered when treating implants or in edentulous areas.*
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material), each additional contiguous tooth*: Not covered when treating implants or in edentulous areas.*
D4355 Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit: *Limited to once per lifetime.*
D4999 Periodontal procedure, unspecified by report: *Coverage determined by report. The plan allowance will be determined upon review of the report.*

Prosthodontic services
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 five years old and cannot be made serviceable.*
- *The replacement appliance is required as the result of accidental bodily injury that occurs after the date the person became a covered person and the appliance cannot be made serviceable*.

D5110 Complete denture, maxillary.
D5120 Complete denture, mandibular.
D5130 Immediate denture, maxillary.

D5140 Immediate denture, mandibular.
D5211 Maxillary partial denture, resin base, retentive/clasping material, rests and teeth.
D5212 Mandibular partial denture, resin base, retentive/clasping materials, rests and teeth.
D5213 Maxillary partial denture, cast metal framework with resin denture base, including retentive/clasping materials rests and teeth.
D5214 Mandibular partial denture, cast metal framework with resin denture base, 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.
D5286 Removable unilateral partial denture, one-piece resin, including retentive/clasping materials, rests and teeth, per quadrant.
D5876 Add metal substructure to acrylic full 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 predominately 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 predominately 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 Resin retainer, for resin bonded fixed prosthesis.
*D6601 Retainer inlay, porcelain/ceramic, three or more surfaces.
*D6604 Retainer Inlay, cast predominantly base metal, two surfaces.
*D6605 Retainer Inlay, cast predominantly base metal, three or more surfaces.
D6613 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 predominately base metal.
*D6752 Retainer crown, porcelain fused to noble metal.
*D6753 Retainer crown, porcelain fused to titanium and titanium alloys.

*D6780 Retainer crown, ¾ cast high noble metal.
*D6781 Retainer crown, ¾ cast predominately base metal.
*D6782 Retainer crown, ¾ cast noble metal.
*D6783 Retainer crown, ¾ porcelain/ceramic.
*D6784 Retainer crown, ¾ titanium and titanium alloys.
*D6790 Retainer crown, full cast high noble metal.
*D6791 Retainer crown, full cast predominately base metal.
*D6792 Retainer crown, full cast noble metal.
*D6794 Retainer crown, titanium and titanium alloys.

Current Dental Terminology © American Dental Association

Implant services

Implant Services – The following implant procedure codes may be allowed under the implant benefit. We will limit payment on covered implant(s) - including abutment, implant, crown, implant-supported appliances such as partial denture (bridge), pontic, full denture and other implant procedures to a calendar year maximum of $2,500 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.

*D6010 Surgical placement of implant body: endosteal implant
*D6013 Surgical placement of mini implant
*D6040 Subperiosteal implant
*D6050 Transosseous mandibular implant
*D6055 Connecting bar - implant supported or abutment supported
*D6056 Prefabricated abutment – includes modification and placement
*D6057 Custom abutment – includes modification and placement
*D6058 Abutment supported porcelain/ceramic crown
*D6059 Abutment supported porcelain fused to metal crown (high noble metal)
*D6060 Abutment supported porcelain fused to metal crown (predominantly based metal)
*D6061 Abutment supported porcelain fused to metal crown (noble metal)
*D6062 Abutment supported cast metal crown (high noble metal)
*D6063 Abutment supported cast metal crown (predominantly based metal)
*D6064 Abutment supported cast metal crown (noble metal)
*D6065 Implant supported porcelain/ceramic crown.
*D6066 Implant supported 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, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis.
D6081 Scaling and debridement in the presence of inflammation of mucositis of a single implant,

including cleaning of the implant surfaces, without flap entry and closure*: Limited to a maximum of once every two calendar years. Coverage determined by report.*
*D6082 Implant supported crown, porcelain fused to predominately 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.
D6090 Repair implant supported prosthesis, by report.
D6091 Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment.
D6092 Re-cement implant/abutment supported crown.
D6093 Re-cement implant/abutment supported fixed partial denture.
*D6094 Abutment supported crown, titanium and titanium alloys.
D6095 Repair implant/abutment, by report.
D6096 Remove broken implant 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 of peri-implant defect: *Limited to once per implant, per lifetime.*
D6104 Bone graft at the time of implant placement.
*D6110 Implant/abutment supported removable denture for edentulous arch, maxillary.
*D6111 Implant/abutment supported removable denture for edentulous arch, mandibular.
*D6112 Implant/abutment supported removable denture for partially edentulous arch, maxillary.
*D6113 Implant/abutment supported removable denture for partially edentulous arch, mandibular.
*D6114 Implant/abutment supported fixed denture for edentulous arch, maxillary.
*D6115 Implant/abutment supported fixed denture for edentulous arch, mandibular.
*D6116 Implant/abutment supported fixed denture for partially edentulous arch, maxillary.
*D6117 Implant/abutment supported fixed denture for partially edentulous arch, mandibular.
*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 Semi-precision abutment, placement.
*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.
*D7994 Surgical placement, zygomatic implant.

Not covered

- *Any implant placement or removal, appliance placed on, or services associated with implants not specifically listed above.*
- *Any implant services or treatment provided primarily for cosmetic purposes.*
- *Initial placement of implants in edentulous arch when existing complete denture exists (i.e., GEHA will not upgrade the denture).*

Adjunctive general services

Sedation/anesthesia/Inhalation of nitrous oxide/analgesia, anxiolysis: Deep sedation/general anesthesia and intravenous conscious sedation and inhalation of nitrous oxide/analgesia, anxiolysis are covered only when provided in connection with a covered procedure(s) and when determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions. To be covered, the procedure for which deep sedation/general anesthesia and intravenous conscious sedation and inhalation of nitrous oxide/analgesia, anxiolysis was provided must be submitted along with a report of why anesthesia/analgesia was necessary.

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.*

D9222 Deep sedation/general anesthesia, first 15 minutes.

D9223 Deep sedation/general anesthesia, each subsequent 15-minute increment.

D9230 Inhalation of nitrous oxide/analgesia, anxiolysis: not covered if performed in conjunction with procedures D9222, D9223, D9239, D9243D9239 Intravenous moderate (conscious) sedation/analgesia, first 15 minutes.

D9243 Intravenous moderate (conscious) sedation/analgesia, each subsequent 15-minute increment.

D9610 Therapeutic drug injection: *Not covered if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication. Coverage determined by report.*

D9612 Therapeutic parenteral drugs, two or more administrations and different medications: *Not covered if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication. Coverage determined by report.*

D9613 Infiltration of sustained release therapeutic drug, per quadrant. *When covered, D9613 once per date of service for members up to age 22, when submitted with extractions (D7220-D7241 & D7251) not to exceed a maximum allowable of $300 per date of service.*

D9930 Treatment of complications (post-surgical) unusual circumstances, by report: *Coverage determined by report.*

Cleaning and inspection of removable dentures, which include D9932, D9933, D9934 and D9935, are limited to once per calendar year, not within six months of D1110: Considered integral if provided on the same date of service as D1110.
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.
Occlusal guards, which include D9944, D9945 and D9946, are limited to once per calendar year for covered person aged 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.
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: Covered for endodontically treated anterior teeth once per covered person per tooth every three calendar years. External bleaching of discolored teeth is not covered.
*D9999 Unspecified adjunctive procedure, by report: Plan allowance will be determined upon review of the report.

Not covered

- Precision attachments, personalization, precious metal bases and other specialized techniques.
- Replacement of dentures that have been lost, stolen or misplaced.
- Removable or fixed prostheses initiated prior to the effective date of coverage or inserted/cemented after the coverage ending date.
- Any exclusions or limitations.

Class D: Orthodontics (FEDVIP covered 70% High in-network, 70% High out-of-network, 50% Standard in-network, 50% Standard out-of-network. Benefits are based on plan allowance.) Important things providers should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible for this plan.
- There is a lifetime maximum benefit of $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.
- 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.
- The Dental plan does not require a pre-determination of benefits. GEHA will respond to a request to pre-determine services with an estimate of covered service, which is not a guarantee of payment since future changes such as changes in member enrollment or eligibility under the dental plan may affect benefits. We encourage members to ask their provider to request a pre-determination for any extensive treatment. By obtaining a pre-determination, the member and their 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 members in making an informed decision on how to proceed with treatment and can help protect members 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 TRICARE Dental Program (TDP) enrollees will be covered for the 2024 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 correction of mild-moderate crowding or spacing.

Orthodontic services

- 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 allowed amount will be divided by the number of months for the total treatment plan. Each resulting portion will be considered to be incurred on a quarterly basis until the lifetime maximum is paid, treatment is completed or eligibility ends, whichever comes first.

  For example: When a provider bills $3,600 for a 24-month treatment plan including miscellaneous services, we will divide our allowable by 24 months ($3,600 divided by 24 months equals $150 per month). Our quarterly allowable will be $150 times 3 months or $450. Our allowable is reimbursed at 70% for a quarterly payment of $315. As the treatment plan is 24 months and we pay quarterly, we will process 8 quarterly payments, 7 payments at $315 and the last payment at $295, which equals $2,500 (member's lifetime maximum). Members will owe the difference between the billed amount and our payment ($3,600 less $2,500 equals $1,100).

- Verification that the covered person is still receiving active treatment is required from the provider once every three months.

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 to 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 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 Removable appliance therapy, minor treatment to control harmful habit.
D8220 Fixed appliance therapy, minor treatment to control harmful habit.
D8660 Pre-orthodontic treatment examination to monitor growth and development.
D8670 Periodic orthodontic treatment visit. When part of the contract, a periodic orthodontic treatment visit is considered part of complete orthodontic treatment plan and not reimbursable as a separate service.
D8680 Orthodontic retention, removal of appliances, construction and placement of retainer(s), 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.

Not covered

- Repair of damaged orthodontic appliances.
- Replacement of lost or missing appliance.
- Any exclusions or limitations.
- Mail order or online orthodontic services and supplies or any treatment related to mail order orthodontic services and supplies.

Additional GEHA Connection Dental Federal® information: Cost for covered services
The following is what members will pay out-of-pocket for covered care.

Copayment
A copayment is a fixed amount the member pays to the provider for services.

- GEHA Connection Dental Federal® High option: No copay
- GEHA Connection Dental Federal® Standard option: No copay

Deductible
A deductible is a fixed amount of expenses members 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 B and C are subject to a combined $25 deductible per person, per calendar year. The maximum deductible for family coverage is $75.

Coinsurance

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

Note: If the provider routinely waives (does not require the member to pay) the 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 the dentist ordinarily charges $100 for a service but routinely waives the 50 percent coinsurance, the actual charge is $50. We will pay $25, 50% of the actual charge of $50.

Annual benefit maximum

Once a member reaches this amount, the member is 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. 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 service are limited to an annual maximum of $2,000 per covered person, included in the annual benefit maximum.

Lifetime benefit maximum

The lifetime benefit maximum applies to orthodontic (Class D) covered services only. Once a member reaches this amount, the member is 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 the member does not remain continuously enrolled. Any amount applied to the lifetime benefit maximum while previously covered under this plan will apply toward the lifetime benefit maximum when a member re-enrolls with this plan.

If the member changes 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 the member's old option to the lifetime benefit maximum of the member's new option.

Plan allowance

The plan allowance is the amount we allow for a specific procedure. When the member uses a participating provider, the member's 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 provider's contracted fee schedule. When the member uses an out-of-network provider, the member is responsible for the difference between our payment and the billed amount.

Subrogation

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

Federal laws

Federal laws supersede state laws including, but not limited to, coordination of benefits, subrogation, claim processing, provider filing and provider processing.

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 2024 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 2024 plan year such as crowns and implants.

Not covered in GEHA Connection Dental Federal®

Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care or treatment of a covered condition.

We do not cover the following:

- Any dental service or treatment not specifically listed as a covered service.
- Missed or canceled appointments, completion of claim form required by us or forwarding records requested by us.
- Dentures that have been lost, stolen or misplaced.
- Duplicate and temporary dentures, appliances, devices, radiographic images and services.
- Experimental services or treatment not generally recognized by the dental profession as necessary for treatment of the condition or for which there is no reasonable expectation of effective treatment.
- Services or treatment provided for oral hygiene instruction or dietary counseling for the control of dental caries and plaque.
- Services or treatment provided by or paid for by any government or government employed dental practitioner unless the covered person is legally required to pay for such services or supplies.
- Services or treatment for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the law or regulation of any governmental unit. This exclusion applies whether or not the member claims the benefit or compensation.
- Services or treatment of congenital malformations, including congenitally missing teeth.
- Repair or replacement of orthodontic appliances.
- Services or treatment provided primarily for cosmetic purposes.
- Service, supplies or treatment furnished by members, their household 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.
  - Participating in a riot, rebellion or insurrection.
- Office infection control.
- Any implant placement or removal, appliances placed on, or services associated with implants not specifically listed, Class C, implant services, including but not limited to anesthesia and IV sedation, ridge augmentation and grafting procedures.
- Any procedure, appliance or restoration that alters the bite and/or restores or maintains the bite. Bite means the way teeth meet or occlusion and vertical dimension. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restorations for malalignment of teeth. This exclusion does not apply to Class D covered services.

- Any treatment related to mail order or online orthodontic services and supplies.
- 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 member's 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.
- Services or treatments that are necessary due to patient failure to follow the dental practitioner's instructions.
- Services or treatments that are not the least costly alternative that accomplishes a result that meets accepted standards of professional dental care as determined by us.
- Any service or treatment that is part of the complete dental procedure is considered a component of, and is included in, the fee for the complete procedure.
- Services received from a dental or medical department maintained by or on behalf of any employer, mutual benefit association, labor union, trust or similar person or group.
- Services performed by a dentist who is compensated by a facility for similar covered services performed for members.
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
- Service or care required as a result of complications from a treatment or service not covered under the Dental plan.
- Fraudulent claims for service.
- Claims submitted later than December 31 of the calendar year following the one in which the expense was incurred, except when the member was legally incapable.
- State or territorial taxes on dental services performed.
- Adjunctive dental services as defined by applicable Federal regulations. The Federal dental program does not cover adjunctive dental care services. These are medical services that are covered by other medical insurance even when provided by a general dentist or oral surgeon. The following diagnoses or conditions may fall under this category:
    - Treatment for relief of myofacial pain dysfunction syndrome or temporomandibular joint dysfunction (TMJD).
    - Orthodontic treatment for cleft lip or cleft palate, or when required in preparation for, or as a result of, trauma to teeth and supporting structures caused by medically necessary treatment of an injury or disease.
    - Procedures associated with preventative and restorative dental care when associated with radiation therapy to the head or neck unless otherwise covered as a routine preventative procedure under this plan.

- Total or complete ankyloglossia.
- Intraoral abscesses that extend beyond the dental alveolus.
- Extraoral abscesses.
- Cellulitis and osteitis, which is clearly exacerbating and directly affecting a medical condition currently under treatment.

- Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.
- Prosthetic replacement of either the maxilla or mandible due to reduction of body tissues associated with traumatic injury (such as a gunshot 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.

Member appeals and provider disputes

Follow this disputed claims process if the member disagrees with our decision on their claim or request for services. The FEDVIP law does not provide a role for OPM to review disputed claims.

Disputed claim steps

Ask us in writing to reconsider our initial decision by requesting a formal appeal. The member must:

- Write to us within six months from the date of our decision; and
- Send the request to us by email: GEHADentalAppeals@geha.com, by fax: 816-257-3268 or by mail: GEHA Connection Dental Federal, P.O. Box 21542, Eagan, MN 55121-9930; and
- Include a statement about why the member believes our initial decision was wrong, based on specific benefit provisions in this brochure; and
- Include copies of documents that support the member's claim, such as dentist's letters, provider narratives, X-rays or other records and explanation of benefits (EOB) forms.

If members do not agree with our final decision, members 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 member's claim.

To request an independent third-party review member must:

- Write to us within 90 days of our letter maintaining denial; and
- Send the request to us by email: GEHADentalAppeals@geha.com, by fax: 816-257-3268 or by mail: GEHA Connection Dental Federal, P.O. Box 21542, Eagan, MN 55121-9930; and
- Include a statement about why members are requesting an independent third-party final appeal review. This statement should include why members believe our decision to deny the member's claim was wrong, based on specific benefit provisions in this brochure; and include copies of documents that support member's claim, such as dentist's letters, provider narratives, X-rays or other records and explanation of benefits (EOB) forms.

The independent third party will review the final appeal disputed claim request and will use the information sent by the member, the provider and us to decide whether our decision is correct. The member 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 the member's claim. This decision is not subject to judicial review.

Part III: GEHA Connection Dental Plus: Covered services

Covered services shall include only those services specifically listed in the Covered Services List. Covered services are subject to alternative benefit, coinsurance, deductibles, maximum benefit limits, waiting periods and the other limitations described herein. We will consider any benefits payable by other dental coverage members have before we calculate benefits payable by us.

Class A, Class B and Class C covered services have a combined calendar year maximum benefit per covered person of $1,200.

Class A: Covered services do not have a waiting period or deductible. We will pay different benefit percentages for participating providers and non-participating providers.

Class A covered services shall be limited as follows:

- Oral evaluations (all types) and prophylaxis: Maximum of two times per calendar year.
- Bitewing X-rays: Maximum of one time per calendar year.
- Topical fluoride application: Limited to covered persons under age 18, maximum of once per calendar year.

Class B: Covered services do not have a waiting period. There is a $50 calendar year deductible per covered person. We will pay different benefit percentages for participating providers and non-participating providers.

Class B covered services shall be limited as follows:

- Full mouth X-rays/panoramic X-rays: Maximum of once every four calendar years.
- Sealants on the occlusal (biting) surfaces of unrestored permanent teeth only: Limited to covered persons under age 18, maximum of one per tooth per lifetime.
- Space maintainer for prematurely lost teeth: Limited to initial appliance(s) only for covered persons age 12 and under.
- Restorations: Limited to one restoration per tooth surface every two calendar years.
- Prefabricated stainless-steel crowns: Limited to primary teeth only for covered persons under age 18, one per tooth every three calendar years.
- Prefabricated esthetic coated stainless steel crowns: Limited to anterior primary teeth only for covered persons under age 18, one per tooth every three calendar.
- Adjustment to denture and partial denture: Limited to two per calendar year, at least six months after delivery of appliance.

Class C: Covered services have a 12-month waiting period and a $100 calendar year deductible per covered person. We will pay different benefit percentages for participating providers and non-participating providers.

Class C covered services shall be limited as follows:

- Inlays and onlays, when required for restorative purposes: Subject to least costly, dentally accepted material.
  - Replacement inlays and onlays are limited to one per tooth, five years after initial or prior placement unless required as a result of an accidental bodily injury.
- Crowns, when required for restorative purposes: Subject to least costly, dentally accepted material.
  - Replacement crowns are limited to one per tooth, five years after initial or prior placement unless required as a result of an accidental bodily injury.
- Recement inlays, onlays, crowns, cast or prefabricated post and core: Limited to one per tooth per calendar year, at least six months after initial placement.
- Therapeutic pulpotomy: For covered persons under 18 years of age.
- Clinical crown lengthening, hard tissue: One per tooth per lifetime.
- Retreatment of root canal: At least 12 months after prior root canal therapy.
- Periodontal scaling and root planning: Limited to once per quadrant every two calendar years.
- Periodontal maintenance: Limited to two times per calendar year.
- Initial prosthodontic appliance (e.g., fixed bridge restoration, removable partial or complete denture, etc.) will be considered a covered service only when it replaces a functioning natural tooth extracted after the effective date of coverage.
- The replacement of an existing prosthodontic device will be considered a covered service only if at least one of the following conditions is met:
  - The replacement appliance is required because at least one natural tooth was necessarily extracted after the date the person became a covered person and the existing appliance could not have been made serviceable. If the existing appliance could have been made serviceable, benefits will be payable only for the expense for that portion of the replacement appliance that replaces the natural teeth extracted after the date the person became a covered person.
  - The replacement appliance replaces an existing appliance that is at least five 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.
- Denture rebase, reline or tissue conditioning: Maximum of once in any 12 consecutive month period and only 12 months after initial insertion.
- Recement fixed partial denture: Limited to one per calendar year, after 12 months have passed since initial placement.
- Replacement of all teeth and acrylic on cast metal frame: Limited to once every five years.
- General anesthesia: Limited to complex covered oral surgery.
- Gingivectomy, gingivoplasty, gingival flap procedure and osseous surgery: Limited to once per quadrant every two calendar years.
- Tissue graft procedures are not covered when treating implants or in edentulous areas.
- Scaling in presence of generalized moderate or severe gingival inflammation limited to once every two calendar years.

Class D: Covered services apply only to a covered child. A covered child is defined for purposes of Class D covered services as a child age six or older but less than 18 years of age.

Class D covered services have a 24-month waiting period per covered child. There is no deductible. We will pay up to $50 per month toward covered treatment by participating providers or up to $25 a month toward covered treatment by non-participating providers.

Orthodontic care includes the coordinated diagnosis and treatment of a full-banded case. The limitations on Class D covered services shall be:

- Maximum benefit payable each calendar year per covered child is $600 toward covered treatment by a participating provider or $300 toward covered treatment by a non-participating provider.
- Lifetime maximum benefit per covered child is $1,200 toward covered treatment by a participating provider or $600 toward covered treatment by a non-participating provider.
- Covered services are limited to an active treatment phase that begins when the bands are first placed on the teeth and ends after 24 consecutive months or when the bands are removed from the teeth, whichever comes first.
- Initial placement of the bands on the teeth must be incurred after the dependent child is a covered child.
- Covered services are limited to the portion of active treatment incurred while the dependent child is a covered child.
- The active treatment phase must be at least six consecutive months in length.
- Benefits for active treatment will end 24 months from initial placement of bands or when bands are removed from the teeth, whichever comes first.

Orthodontia services not covered

- Mail order or online orthodontic services and supplies or any treatment related to mail order orthodontic services and supplies.
- Limited orthodontic treatment.
- Interceptive orthodontic treatment.
- Minor orthodontic treatment for tooth guidance to control harmful habit.

Benefits will not be payable for any services not specifically listed in the covered service list. In addition, benefits will not be payable for any expense incurred for or in connection with:

- Services or treatment for the provision of an initial prosthodontic appliance (e.g., fixed bridge restoration, removable partial or complete denture, etc.) when it replaces natural teeth extracted or missing, including due to congenital defects, prior to the effective date of coverage.
- Missed or canceled appointments, telephone consultations, completion of claim form required by us or forwarding records requested by us.
- Dentures that have been lost, stolen or misplaced.
- Duplicate dentures, appliances, devices or X-rays.
- Services or treatment not generally recognized by the dental profession as necessary for treatment of the condition that are experimental, 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 covered by any workers' compensation law or act or similar legislation.

- Congenital malformations.
- Repair or replacement of orthodontic appliance.
- Services or treatment provided primarily for cosmetic procedures.
- Services or treatment provided by a member of the member's immediate family or a member of the immediate family of the member's spouse.
- 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.
- 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
  - Participating in a riot, rebellion or insurrection
- Office infection control.
- Implant placement or removal, appliances placed on, or services associated with implants.
- 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, and restoration of tooth structure lost from attrition, erosion or abrasion, restorations for malalignment of teeth. This exclusion does not apply to Class D covered services.
- Services or treatment started or performed before the effective date of coverage.
- Diagnosis and/or treatment of jaw joint problems, including temporomandibular joint (TMJ) syndrome, craniomandibular disorders, or other conditions of the joint linking the jaw bone 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.
- Precision dentures or characterization or personalization of crowns, dentures or restorations.
- Services or treatment that are necessary due to patient failure to follow the dental practitioner's instructions.
- Services or treatment that are not the least costly alternative treatment that accomplishes a result that meets accepted standards of professional dental care as determined by us.
- Any services or treatment that are part of the complete dental procedure. These services or treatment are considered components of, and included in, the fee for the complete procedure.
- Services rendered after the termination of coverage, except under elected continuation of coverage.
- Services paid for by the Federal Employee Health Benefit 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 calendar year in which the expense was incurred, except when the member was legally incapable.
- Any treatment related to mail order or online orthodontic services and supplies.

GEHA Connection Dental Plus covered services list

Covered services shall include only those services listed specifically below. Covered services are subject to alternative benefit, coinsurance, deductibles, maximum benefit limits, Predetermination of benefits, waiting periods and the other limitations and exclusions described in the Connection Dental Plus plan brochure. The Dental plan reserves the right to add, change or delete procedures as required by changes in Current Dental Terminology © American Dental Association. Services listed with an asterisk (*) often have a choice of a lower cost treatment.

Class A: No deductible, no waiting period

D0120 Periodic oral evaluation, established patient.
D0140 Limited oral evaluation, problem focused.
D0145 Oral evaluation for a patient under age three and counseling with primary caregiver.
D0150 Comprehensive oral evaluation, new or established patient.
D0180 Comprehensive periodontal evaluation, new or established patient.
D0270 Bitewing, single radiographic image.
D0272 Bitewings, two radiographic images.
D0273 Bitewings, three radiographic images.
D0274 Bitewings, four radiographic images.
D0277 Vertical bitewings, seven to eight radiographic images preventive.
D1110 Prophylaxis adult.
D1120 Prophylaxis child.
*D1206 Topical application of fluoride varnish.
*D1208 Topical application of fluoride, excluding varnish.

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Class B: $50 calendar year deductible per person, no waiting period diagnostic

D0210 Intraoral, complete series of radiographic images.
D0220 Intraoral, periapical, first radiographic image.
D0230 Intraoral, periapical, each additional radiographic image.
D0330 Panoramic radiographic image preventive.
D1351 Sealant, per tooth.
D1354 Interim caries arresting medicament application.
D1510 Space maintainer, fixed unilateral.
D1516 Space maintainer, fixed bilateral, maxillary.
D1517 Space maintainer, fixed bilateral, mandibular.
D1520 Space maintainer, removable unilateral.
D1526 Space maintainer, removable bilateral, maxillary.
D1527 Space maintainer, removable bilateral, mandibular.
D1575 Distal shoe space maintainer, fixed, unilateral restorative.
D1352 Preventive resin restoration in a moderate to high caries risk patient, permanent tooth.
D2140 Amalgam, one surface, primary or permanent.
D2150 Amalgam, two surfaces, primary or permanent.
D2160 Amalgam, three surfaces, primary or permanent.
D2161 Amalgam, four or more surfaces, primary or permanent.
D2330 Resin-based composite, one surface, anterior.
D2331 Resin-based composite, two surfaces, anterior.

D2332 Resin-based composite, three surfaces, anterior.
D2335 Resin-based composite, four or more surfaces or involving incisal angle, anterior.
D2391 Resin-based composite, one surface, posterior.
D2392 Resin-based composite, two surfaces, posterior.
D2393 Resin-based composite, three surfaces, posterior.
D2394 Resin-based composite, four or more surfaces, posterior.
*D2929 Prefabricated porcelain/ceramic crown, primary tooth.
D2930 Prefabricated stainless steel crown, primary tooth.
D2934 Prefabricated esthetic coated stainless steel crown, primary tooth.
D2951 Pin retention, per tooth, in addition to restoration prosthodontics, removable.
D5410 Adjust complete denture, maxillary.
D5411 Adjust complete denture, mandibular.
D5421 Adjust partial denture, maxillary.
D5422 Adjust partial denture, mandibular 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, complete bony.
D7250 Removal of residual tooth roots, cutting.
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 space, per quadrant.
D7450 Removal of benign odontogenic cyst or tumor, lesion diameter up to 1.25cm.
D7510 Incision and drainage of abscess, intraoral soft tissue.
D7511 Incision and drainage of abscess, intraoral soft tissue complicated, includes drainage of multiple fascial spaces.
D7960 Frenulectomy, also known as frenectomy or frenotomy separate procedure not Incidental to another procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue, per arch.
D7971 Excision of pericoronal gingiva.

Miscellaneous

D9110 Palliative (ER) treatment of dental pain, minor procedure.
D9910 Application of desensitizing medicament.

Class C: $100 calendar year deductible per person, 12-month waiting period restorative

D2390 Resin-based composite crown, anterior.
*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.
*D2630 Inlay, porcelain/ceramic, three or more surfaces.
*D2643 Onlay, porcelain/ceramic, three surfaces.
*D2644 Onlay, porcelain/ceramic, four or more surfaces.
*D2710 Crown, resin-based composite, indirect.
*D2712 Crown, ¾ 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.
D2781 Crown, ¾ cast predominately base metal.
*D2790 Crown, full cast high noble metal.
D2791 Crown, full cast predominantly base metal.
*D2792 Crown, full cast noble metal.
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
D2920 Re-cement or re-bond crown.
D2940 Protective restoration.
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.
D2954 Prefabricated post and core in addition to crown.
*D2957 Each additional prefabricated post, same tooth.

Endodontics

D3110 Pulp cap, direct, excluding final restoration.
D3220 Therapeutic pulpotomy, excluding final restoration, removal of pulp coronal to the dentinocemental junction and application of medicament.
D3221 Pulpal Debridement, primary and permanent teeth.
D3222 Partial pulpotomy for apexogenesis, permanent tooth with incomplete root development.
D3310 Endodontic therapy, anterior tooth, excluding final restoration.
D3320 Endodontic therapy, premolar tooth, excluding final restoration.
D3330 Endodontic therapy, molar, excluding final restoration.
D3346 Retreatment of previous root canal therapy, anterior.
D3347 Retreatment of previous root canal therapy, premolar.
D3348 Retreatment of previous root canal therapy, molar.
D3410 Apicoectomy, anterior.
D3421 Apicoectomy, bicuspid, first root.
D3425 Apicoectomy, molar, first root.
D3426 Apicoectomy, each additional root.
D3427 Periradicular surgery without apicoectomy.
D3428 Bone graft in conjunction with periradicular surgery.
D3429 Bone graft in conjunction with periradicular surgery, each additional contiguous tooth in the same surgical.
D3431 Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery.
D3432 Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery.
D3430 Tooth in the same surgical site.

Periodontics

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.
D4240 Gingival flap procedure, including root planing, four or more contiguous teeth or tooth bounded spaces per quadrant.
D4241 Gingival flap procedure, including root planning, one to three contiguous teeth or tooth bounded spaces per quadrant.
D4249 Clinical crown lengthening, hard tissue.
D4260 Osseous surgery, including elevation of a full thickness flap and closure, four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery including elevation of a full thickness flap and closure, one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft, retained natural tooth, first site in quadrant.
D4264 Bone replacement graft, retained natural tooth, each additional site in quadrant.
D4266 Guided tissue regeneration, resorbable barrier, per site.
D4267 Guided tissue regeneration, non-resorbable barrier, per site, including membrane removal.
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.
D4276 Combined connective tissue and double pedicle graft, per tooth.
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.
D4341 Periodontal scaling and root planning, four or more teeth per quadrant.
D4342 Periodontal scaling and root planning, one to three teeth, per quadrant.
D4346 Scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation.
D4910 Periodontal maintenance.

Prosthodontics: Removable

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 any conventional clasps, rests and teeth.
D5214 Mandibular partial denture, cast metal framework with resin denture bases, including any conventional clasps, rests and teeth.
D5221 Immediate maxillary partial denture, resin base, including any conventional clasps, rests and teeth.
D5222 Immediate mandibular partial denture, resin base, including any conventional clasps, rests and teeth.
D5223 Immediate maxillary partial denture, cast metal framework with resin denture bases, including any conventional clasps, rests and teeth.
D5224 Immediate mandibular partial denture, case metal framework with resin denture bases, including any conventional clasps, rests and teeth.
D5225 Maxillary partial denture, flexible base, including clasps, rests and teeth.
D5226 Mandibular partial denture, flexible base, including clasps, rests and teeth.
D5282 Removable unilateral partial denture, one piece cast metal, including claps and teeth, maxillary.
D5283 Removable unilateral partial denture, one piece cast metal, including claps and teeth, mandibular.

D5511 Repair broken complete denture base, mandibular.
D5512 Repair broken complete denture base, maxillary.
D5520 Replace missing or broken teeth, complete denture, each 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 material, per tooth.
D5640 Replace broken teeth, per tooth.
D5650 Add tooth to existing partial denture.
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.
D5730 Reline complete maxillary denture, chairside.
D5731 Reline complete mandibular denture, chairside.
D5740 Reline maxillary partial denture, chairside.
D5741 Reline mandibular partial denture, chairside.
D5750 Reline complete maxillary denture, laboratory.
D5751 Reline complete mandibular denture, laboratory.
D5760 Reline maxillary partial denture, laboratory.
D5761 Reline mandibular partial denture, laboratory.
D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.
D5876 Add metal substructure to acrylic full denture, per arch.

Prosthodontics: Fixed

D6205 Pontic, indirect resin-based composite.
*D6210 Pontic, cast high noble metal.
D6211 Pontic, cast predominantly base metal.
*D6212 Pontic, cast noble metal.
*D6240 Pontic, porcelain fused to high noble metal.
D6241 Pontic, porcelain fused to predominantly base metal.
*D6242 Pontic, porcelain fused to noble metal.
*D6245 Pontic, porcelain/ceramic.
*D6250 Pontic, resin with high noble metal.
D6251 Pontic, resin with predominantly base metal.
*D6252 Pontic, resin with noble metal.
D6600 Retainer inlay, porcelain/ceramic, two surfaces.
D6601 Retainer inlay, porcelain/ceramic, three or more surfaces.
*D6602 Retainer inlay, cast high noble metal, two surfaces.
*D6603 Retainer inlay, cast high noble metal, three or more surfaces.
D6604 Retainer inlay, cast predominantly base metal, two surfaces.
D6605 Retainer inlay, cast predominantly base metal, three or more surfaces.
*D6606 Retainer inlay, cast noble metal, two surfaces.
*D6607 Retainer inlay, cast noble metal, three or more surfaces.
D6608 Retainer onlay, porcelain/ceramic, two surfaces.
D6609 Retainer onlay, porcelain/ceramic, three or more surfaces.
*D6610 Retainer onlay, cast high noble metal, two surfaces.
*D6611 Retainer onlay, cast high noble metal, three or more surfaces.
D6612 Retainer onlay, cast predominately base metal, two surfaces.
D6613 Retainer onlay, cast predominately base metal, three or more surfaces.
*D6614 Retainer onlay, cast noble metal, two surfaces.
*D6615 Retainer onlay, cast noble metal, three or more surfaces.
D6710 Retainer crown, Indirect resin-based composite.
*D6720 Retainer crown, resin with high noble metal.
D6721 Retainer crown, resin with predominantly base metal.
*D6722 Retainer crown, resin with noble metal.
*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.
*D6780 Retainer crown, ¾ cast high noble metal.
D6781 Retainer crown, ¾ cast predominately base metal.
*D6782 Retainer crown, ¾ cast noble metal.
*D6783 Retainer crown, ¾ porcelain/ceramic.
*D6790 Retainer crown, full cast high noble metal.
D6791 Retainer crown, full cast predominantly base metal.
*D6792 Retainer crown, full cast noble metal.
D6930 Re-cement or re-bond fixed partial denture.

Class D: No deductible, 24-month waiting period, limited to covered child

Orthodontics

D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition

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Claims provisions

How to file claims

Bills and receipts should be itemized and show:

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

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

If members are a GEHA health plan member, send dental claims to:

GEHA Connection Dental Plus
P.O. Box 21542
Eagan, MN 55121-9930

If members are not a GEHA health plan member, members must first submit the members dental claim to their other plan(s), then submit the member's dental claim to Connection Dental Plus, along with the other plan's Explanation of Benefits (EOB).

If members need help in filing their claim, the member can call us toll-free at 800.793.9335 or TDD 800.821.4833.

Keep a separate record of the dental expenses of each covered person, as deductibles and maximum benefit limits apply separately to each covered person. Save copies of all dental bills, including those members accumulate to satisfy a deductible. In most instances, they will serve as evidence of the member's claim. We will not provide duplicate or year-end statements.

Claims should be filed within 90 days from the date the expense for which claim is being made was incurred, unless timely filing was prevented by legal incapacity, provided the claim was submitted as soon as reasonably possible. We will not accept a claim submitted later than December 31 of the calendar year following the one in which the expense for which the claim is being made was incurred, except when the member was legally incapable. We may, at our option, require supporting documentation such as clinical reports, charts, X-rays and study models.

Examination

We have the right, at our expense, to have anyone on whom a claim is based to be examined by a dental practitioner of our choice during the pendency of the claim.

Payment of benefits

Unless another order of payment is specified herein, all Dental plan benefits are payable in the following order promptly after receipt of the claim:

- To any assignee of record; otherwise
- To the member, if living; otherwise
- To the member's estate.

Facility of payment

If 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.

Assignment of benefits

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 member or dental practitioner at our option, whether or not we receive an assignment of benefits.

Type of claim

Claims for benefits under the Dental plan are deemed to be post-service claims as defined by ERISA and shall be adjudicated in the manner required by ERISA for post-service claims.

Notification of claim decision

The member will be notified of our decision on the member's claim within a reasonable period of time, but no later than 30 days after receipt of the member's claim. If we determine that an extension of time is necessary due to matters beyond the Dental plan's control, we may extend this 30-day period by up to 15 days. If this happens, we will notify the member of the extension before the end of the initial 30-day period. The notice will include a description of the matters beyond the plan's control that justify the extension and the date by which a decision is expected. If an extension is due to a failure to submit the information needed for us to decide the claim, the notice of extension will specifically describe the required information. The member will then be given at least 45 days from the receipt of the notice to provide that information. The Dental plan's deadline for deciding the member's claim shall be suspended from the date the member receives the extension notice until the date the missing necessary information is provided to the plan. If the member provides the requested information, the plan shall decide the claim within the extended period specified in the extension notice. However, if the requested information is not provided within the time specified, the claim may be decided without that information.

Claim denial

In the event a claim is denied, in whole or in part, or if we take another final action, the covered person will be advised of the following:

- The specific reason for the denial.
- Specific reference to the Dental plan provisions on which the denial is based.
- Additional material or information needed for further review of the claim, along with an explanation of why that material or information is needed.
- An explanation of the review procedure, including the time limits applicable to such review.
- A description of the member's right to file suit in court if the member's request for review is denied.

If we relied on an internal rule, guideline, protocol or other similar criterion in denying the member's claim, the notice the member receives will include either the specific rule, guideline, protocol or other similar criterion relied upon, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided to the member free of charge upon the member's request. Similarly, if the member's claim was denied on the basis of dental necessity or an experimental treatment or similar exclusion or limit, the notice will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Dental plan to the member's circumstances, or a statement that such an explanation will be provided to the member free of charge upon the member's request.

Right of review

If a claim is denied, in whole or in part, or if the member desires to have another final action reviewed by us, the member, or an authorized representative acting on the member's behalf, shall have the right to request that we review the benefit denial or other action. For an authorized representative to act on the member's behalf the Dental plan must receive an Appointment of Authorized Representative form signed by the member. Such form can be obtained and submitted to the plan administrator. In connection with any review, the member will have the opportunity to submit written comments, documents, records and other information relating to the member's claim. The member will also have reasonable access, upon request and free of charge, to all documents, records and other information relevant to the member's claim. The member may also obtain copies of those documents, records and other information. The Dental plan provides a two-level appeal system that allows the member's full opportunity to appeal benefit decisions.

Level 1: Formal appeal

To request a formal appeal of a claim denial or other action, the member, or an authorized representative acting on the member's behalf, must file a written request for an appeal with us postmarked within 180 days after the date on which the member received written notice of the denial or other final action. Failure to comply with this important deadline may cause the member to forfeit any right to any further review of a denial of benefits under these procedures or in a court of law. The request must be in writing and include the reason for the request, a copy of the initial determination and any supporting documentation such as X-rays, provider narrative or office notes. Request for an appeal should be sent to:

GEHA Connection Dental Plus Appeals
P.O. Box 21542
Eagan, MN 55121-9930
Fax: 816.257.3268
Email: **GEHADentalAppeals@geha.com**

The request for an appeal will be treated as received by the Dental plan (a) on the date it is hand-delivered to the Dental plan or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the above name and address. The postmark on the envelope will be proof of the date of mailing.

Within 30 days after we receive the member's request for an appeal, the review will be made. Someone other than the person who processed or reviewed the original claim shall make the review of the member's request for an appeal and will give no deference to the initial benefit decision. The review will take into account all information submitted by members, regardless of whether or not the information was available or presented in connection with the initial benefit decision. If the denial was based, in whole or in part, on any medical judgment, we will consult with a health care professional having appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will be different from any individual consulted in connection with the original claim decision and will not be a subordinate of any such individual. If the Dental plan obtained advice from any medical experts in making a decision on the member's claim, those experts will be identified during the course of the member's appeal, regardless of whether that advice was relied upon in denying the member's claim.

The decision on our review will be forwarded to the member in writing and will include specific reasons for the decisions, references to provisions upon which the decision was based, further appeal rights and a statement of the member's right to file suit in court to obtain payment of the member's claim for benefits.

If we relied on an internal rule, guideline, protocol or other similar criterion in denying the member's request for an appeal, the notice the member receives will include either the specific rule, guideline, protocol or other similar criterion relied upon, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided to the member free of charge upon the member's request. Similarly, if the member's request for an appeal was denied on the basis of dental necessity or an experimental treatment or similar exclusion or limit, the notice will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Dental plan to the member's circumstances, or a statement that such an explanation will be provided to the member free of charge upon the member's request.

The member shall, upon request and free of charge, be given reasonable access to, and copies of, all documents, records and other information relevant to the member's claim for benefits. If the advice of a medical or vocational expert was obtained, the names of such expert will be provided to the member upon request, regardless of whether the advice was relied on by the Plan.

Level 2: Final appeal

If a claim remains denied after a request for an appeal, the member, or an authorized representative acting on the member's behalf, shall have the right to request a final review of the denial or other action. To request a final review of a claim denial or other action, the member must file a written request for final review postmarked within 90 days after the date of our formal review response. Failure to comply with this important deadline may cause the member to forfeit any right to any further review of a denial of benefits under these procedures or in a court of law. The request must be made in writing and include the reason for the request for final review, copy of our letter and any new information. Requests for a final review should be sent to:

GEHAConnection Dental Plus Appeals
P.O. Box 21542
Eagan, MN 55121-9930
Fax: 816.257.3268
Email: GEHADentalAppeals@geha.com

The request for a final review will be treated as received by the Dental plan (a) on the date it is hand-delivered to the Dental plan or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the above name and address. The postmark on the envelope will be proof of the date of mailing.

Within 30 days after we receive the member's request for a final appeal review, the review shall be made. Someone other than the person(s) who processed or reviewed the earlier reconsideration request shall review all documents submitted to the Dental plan and no deference will be given to any prior decision. The final review will take into account all information submitted by the member, regardless of whether or not the information was available or presented in connection with a prior benefits decision.

If the denial was based, in whole or in part, on any medical judgment, we will consult with a health care professional having appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will be different from any individual consulted in connection with the original claim decision and will not be a subordinate of any such individual. If the Dental plan obtained advice from any medical experts in making a decision on the member's claim, those experts will be identified during the course of the member's appeal, regardless of whether that advice was relied upon in denying member's claim.

The decision on our final review shall be forwarded to the member in writing and shall include specific reasons for the decision and references to provisions upon which the decision was based, a statement indicating the member's entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination and a statement of the member's right to file suit in court to obtain payment of the member's claim for benefits.

The 2024 GEHA Plan Manual for Dental Providers is intended solely as a reference guide. For complete information please refer to the applicable GEHA Brochure(s) available online at https://www.geha.com/resource-center/forms-and-documents.