GEHA Connection Dental Federal[SM]

http://www.gehadental.com

2008

A National Dental PPO Plan

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

This Plan has 6 enrollment regions, including overseas: Please see the end of this brochure to determine your region and corresponding rates.

Enrollment Options for this Plan:

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

ACCREDITED HEALTH NETWORK

URAC accreditation:
GEHA for Dental Network

FEDVIP
Federal Employees
Dental And Vision Insurance Program

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

Introduction

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

This brochure describes the benefits of GEHA Connection Dental Federal under Government Employees Health Association, Inc.'s contract OPM-06-0060-4 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

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

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

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits.

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

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

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

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

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FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas regional, dental Preferred Provider Organizations (PPO), and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Visit www.opm.gov/insure/dentalvision for more information.
Enroll Through BENEFEDS	You enroll through the Internet at www.BENEFEDS.com. Please see Section 2, Enrollment, for more information.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2007 Open Season, your coverage will begin on January 1, 2008. Premium deductions will start with the first full pay period beginning on/after January 1, 2008. You may use your benefits as soon as your enrollment is confirmed.
Pre-Tax Salary Deduction for Employees	Employees automatically pay premiums through payroll deductions using pre-tax dollars. Annuitants automatically pay premiums through annuity deductions using post-tax dollars.
Annual Enrollment Opportunity	Each year, an Open Season will be held, during which you may enroll or change your dental and/or vision plan enrollment. This year, Open Season runs from November 12, 2007 through December 10, 2007. You do not need to re-enroll each Open Season unless you wish to change plans or plan options; your coverage will continue from the previous year. In addition to the annual Open Season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2, Enrollment, for more information.
Continued Group Coverage After Retirement	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may also be able to continue enrollment after your death. Please see Section 1, Eligibility, for more information.
Waiting Period	The only waiting period is for orthodontic services. To meet this requirement, the person receiving the services must be enrolled in the same plan/option for the entire waiting period.

How We Have Changed For 2008

GEHA changed its name from Government Employees Hospital Association, Inc. to Government Employees Health Association, Inc.

We have clarified the following:

- We have clarified how we coordinate benefits with other payers.
- We have clarified our right to recover overpayments.
- We have clarified how the lifetime benefit maximum applies if a person leaves the plan and subsequently re-enrolls.
- We have clarified that we will use the daily exchange rate for the date of service on international claims.

Section 1 Eligibility

Federal Employees

If you are a Federal or U.S. Postal Service employee, you are eligible to enroll in FEDVIP if you are eligible for the Federal Employees Health Benefits (FEHB) Program. Enrollment in the FEHB Program is not required.

Federal Annuitants

You are eligible to enroll if you:

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

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

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

Survivor Annuitants

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

Compensationers

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

Family Members

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

FEDVIP rules and FEHB rules for family member eligibility are the same. For more information on family member eligibility, see the FEHB Handbook at www.opm.gov/insure/handbook or contact your employing agency or retirement system.

Not Eligible

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

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

Section 2 Enrollment

Enroll Through BENEFEDS

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

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

Enrollment Types

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

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

Note: A Self Plus One enrollment option does not exist under the FEHB Program.

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

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee or annuitant, you may enroll in a dental and/or vision plan during the November 12 through December 10, 2007 Open Season. Coverage is effective January 1, 2008.

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

New hire/Newly eligible

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

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

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

Qualifying Life Event

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

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

Qualifying Life Event	From Not Enrolled to Enrolled	INCREASE: Enrollment Type	DECREASE: Enrollment Type	Cancel	CHANGE: from one plan to another
Acquiring an eligible family member	No	Yes	No	No	No
Losing a covered family member	No	No	Yes	No	No
Losing other dental/vision coverage (eligible or covered person)	Yes	Yes	No	No	No
Moving out of regional plan's service area	No	No	No	No	Yes
Going on active military duty, non-pay status	No	No	No	Yes	No
Return to pay status from active military duty	Yes	No	No	No	No
Annuity/compensation restored	Yes	Yes	Yes	No	No

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

- There is no time limit for a change based on moving from a regional plan's service area and
- You cannot request a new enrollment based on a QLE before the QLE occurs. You must make the change no later than 60 days after the event.

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

Canceling an enrollment

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

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

When Coverage Stops

Coverage ends when you:

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

Coverage for a family member ends when:

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

Continuation of Coverage

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

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

FSAFEDS/High Deductible Health Plans and FEDVIP

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

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

Current FSAFEDS participants must re-enroll to participate in 2008. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-800-952-0450.

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you can use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB and FEDVIP plans. You will be required to submit your claim on behalf of the GEHA Connection Dental Federal Plan to the FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA).

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation

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

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

You may also print a temporary ID card through our website: www.gehadental.com.

Where You Get Covered Care

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

Plan Providers

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

In-Network

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

The CONNECTION Dental Network of participating providers is subject to change. It is your responsibility to verify with the participating provider that the provider currently participates in the CONNECTION Dental Network before you receive care.

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

Out-of-Network

Care that you receive from a provider that does not participate in the CONNECTION Dental Network. GEHA reimburses for dental care from any covered provider.

Pre-Authorization

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

To pre-authorize treatment, the dentist should submit a completed dental pre-authorization claim form that itemizes the proposed procedure codes, charge for each procedure along with pretreatment plan, X-rays and any other diagnostic materials.

Coordination of Benefits

If you have dental coverage through your FEHB plan and coverage under FEDVIP, your FEHB plan will be the first payor of any benefit payments. We are responsible for coordinating benefits with the primary FEHB payor.

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

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

We may request that you verify/identify your health insurance plan(s) annually or at the time of service.

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

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

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

For example:

Charge	Other Carrier (s') Payment(s)	Balance	GEHA's Regular Benefit	We Would Pay
$100.00	$30.00	$70.00	$80.00	$70.00 ($100 - $30)

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

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

Rating Areas

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

Limited Access Area

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

Alternate Benefit

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

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

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

Dental Review

Some services require additional information in order to determine if the services are covered or subject to an alternative benefit. X-rays are required for crowns, periodontal procedures, inlays/onlays, multiple fillings and crown build-ups. Charting is required for periodontal procedures. The date of prior placement is required for dentures, partials, crowns and bridges.

For example, an X-ray is required for a crown to determine if services are for restorative purposes and necessary due to decay or tooth fracture and evidence is presented showing the tooth cannot be adequately restored with an amalgam or composite filling.

Section 4 Your Cost For Covered Services

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

Copayment

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

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

GEHA Connection Dental Federal **Standard Option** – $10 copay for Class A services only. Class B, C & D services do not have a copay.

Coinsurance

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

For High Option, your coinsurance is as follows:

- Class A – nothing
- Class B – 20%
- Class C – 50%
- Class D – 70%

For Standard Option, your coinsurance is as follows:

- Class A – nothing after $10 copay
- Class B – 45%
- Class C – 65%
- Class D – 70%

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

Annual Benefit Maximum

Once you reach this amount, you are responsible for all charges. For this plan, there is an annual benefit maximum per person of $1,200 for combined Class A, Class B and Class C covered services. Once the annual benefit maximum has been met, no additional benefits will be paid for Class A, Class B or Class C covered services for that person for that calendar year.

Lifetime Benefit Maximum

Once you reach this amount, you are responsible for all charges. This plan has a lifetime benefit maximum of $1,500 per covered child for Class D covered services. Once the lifetime benefit maximum has been met, no additional benefits will be paid for Class D covered services for that child.

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

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

In-Network Services

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

Out-of-Network Services

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

Emergency Services

Emergency services are covered the same as any other benefit.

Plan Allowance

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

If We Overpay You

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible for this plan.
- The annual benefit maximum is $1,200 per covered person.
- Covered services shall include only those services specifically listed in Section 5, Dental Services and Supplies. A covered service must be incurred and completed while the person receiving the service is a covered person. Covered services are subject to plan provisions for exclusions and limitations and meet acceptable standards of dental practice as determined by us.
- Covered services are limited to the maximum allowable charge as determined by us and are subject to alternative benefit, coinsurance, maximum benefit limits, waiting period and the other limitations described in this plan document.

You pay:

- ***High Option***
- **In-network:** Nothing.
- **Out-of-network:** Any difference between the plan allowance and the billed amount.
- ***Standard Option***
- **In-network:** $10 copay per visit.
- **Out-of-network**: $10 copay per visit and any difference between our allowance and the billed amount.

Diagnostic and treatment services

Oral evaluations (all types) are limited to a maximum of two times per Calendar Year.
D0120 Periodic oral evaluation
D0140 Limited oral evaluation – problem focused
D0150 Comprehensive oral evaluation
D0180 Comprehensive periodontal evaluation
D0210 Intraoral – complete series (including bitewings) – *Full mouth X-rays and panoramic X-rays are limited to a combined maximum of once every Calendar Year.*
D0220 Intraoral – periapical first film
D0230 Intraoral – periapical – each additional film
D0240 Intraoral – occlusal film
D0270 Bitewing – single film – *Limited to twice per Calendar Year.*
D0272 Bitewings – two films – *Limited to twice per Calendar Year.*
D0274 Bitewings – four films – *Limited to twice per Calendar Year.*
D0277 Vertical bitewings – 7 to 8 films – *Limited to twice per Calendar Year.*
D0330 Panoramic film – *Full mouth X-rays and panoramic X-rays are limited to a combined maximum of once every Calendar Year.*
D0425 Caries susceptibility tests
Current Dental Terminology © American Dental Association

Preventative services
D1110 Prophylaxis – adult – *Limited to twice per Calendar Year.*
D1120 Prophylaxis – child – *Limited to twice per Calendar Year.*
Topical application of fluoride is limited to Covered Persons under age 22 twice per Calendar Year.
D1201 Topical application of fluoride (including prophylaxis) – child
D1203 Topical application of fluoride (excluding prophylaxis) – child
D1204 Topical application of fluoride (excluding prophylaxis) – adult
D1205 Topical application of fluoride (including prophylaxis) – adult
D1351 Sealant – per tooth – *Sealants are limited to Covered Persons under 18 years of age on the occlusal (biting) surfaces of unrestored permanent teeth only and are limited to one sealant per tooth every 3 Calendar Years.*
Space maintainers are limited to initial appliance for non-orthodontic treatment of prematurely lost teeth in children under age 19.
D1510 Space maintainer – fixed – unilateral
D1515 Space maintainer – fixed – bilateral
D1520 Space maintainer – removable – unilateral
D1525 Space maintainer – removable – bilateral
D1550 Re-cementation of space maintainer
Additional procedures covered as basic services
D9110 Palliative treatment of dental pain – minor procedure
D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
D9440 Office visit after regularly scheduled hours
Not covered: • *Plaque control programs* • *Oral hygiene instruction* • *Dietary instructions* • *Over-the-counter dental products, such as teeth whiteners, toothpaste, dental floss* • Any exclusions or limitations listed under Section 7 of this plan document
Current Dental Terminology © American Dental Association

Class B Intermediate

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible for this plan.
- The annual benefit maximum is $1,200 per covered person.
- Covered services shall include only those services specifically listed in Section 5, Dental Services and Supplies. A covered service must be incurred and completed while the person receiving the service is a covered person. Covered services are subject to plan provisions for exclusions and limitations and meet acceptable standards of dental practice as determined by us.
- For services listed with an asterisk (*), the choice of a lower cost treatment is available. If you or your dental provider should choose this treatment or service, we will allow the lower cost alternative benefit unless evidence is submitted with the bill to explain why the less expensive treatment could not be done.
- Covered services are limited to the maximum allowable charge as determined by us and are subject to alternative benefit, coinsurance, maximum benefit limits, waiting period and the other limitations described in this document.
- The dental plan does not require pre-authorization of benefits. GEHA will respond to a request to pre-authorize services with an estimate of covered service, which is not a guarantee of payment since future changes such as changes in your enrollment or eligibility under the dental plan may affect benefits. We encourage you to ask your provider to pre-authorize any extensive treatment. By pre-authorizing treatment, you and your dental provider will have an estimate before treatment begins of what will be covered and how it will be paid. This information can be valuable to you in making an informed decision on how to proceed with treatment and can help protect you from unexpected out-of-pocket costs should the treatment plan not be covered.
- To pre-authorize treatment, the dentist should submit a completed dental pre-authorization claim form that itemizes the proposed procedure codes, charge for each procedure along with pretreatment plan, X-rays and any other diagnostic materials.

You Pay:

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

Minor restorative services

Fillings are limited to one restoration per tooth surface every 2 Calendar Years. Subject to least costly, dentally accepted material.

D2140 Amalgam – one surface, primary or permanent

D2150 Amalgam – two surfaces, primary or permanent

D2160 Amalgam – three surfaces, primary or permanent

D2161 Amalgam – four or more surfaces, primary or permanent

D2330 Resin-based composite – one surface, anterior

D2331 Resin-based composite – two surfaces, anterior

D2332 Resin-based composite – three surfaces, anterior

D2335 Resin-based composite – four or more surfaces or involving incisal angle (anterior)

*D2391 Resin-based composite – one surface, posterior

*D2392 Resin-based composite – two surfaces, posterior

*D2393 Resin-based composite – three surfaces, posterior

*D2394 Resin-based composite – four or more surfaces, posterior

*D2610 Inlay – porcelain/ceramic, one surface

*D2620 Inlay – porcelain/ceramic, two surfaces

*D2630 Inlay – porcelain/ceramic, three or more surfaces

D2910 Re-cement inlay – *Limited to once per 6 month period if more than 12-months from initial placement*

D2920 Re-cement crown – *Limited to once per 6 month period if more than 12-months from initial placement*

D2930 Prefabricated stainless steel crown – primary tooth – *Limited to one per patient, per tooth, per lifetime for Covered Persons under 15 years of age*

D2931 Prefabricated stainless steel crown – permanent tooth – *Limited to one per patient, per tooth, per lifetime for Covered Persons under 15 years of age*

D2951 Pin retention – per tooth, in addition to restoration

Not covered:

- *Restorations, including veneers, which are placed for cosmetic purposes only*
- *Gold foil restorations*
- *Any exclusions or limitations listed under Section 7 of this plan document*

Endodontic services

D3220 Therapeutic pulpotomy (excluding final restoration) –*Therapeutic pulpotomy is limited to once per primary tooth per lifetime.*

D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) – *Limited to primary incisor teeth for children up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.*

D3240 Pulpal therapy (resorbable filling) – posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. – *Limited to primary incisor teeth for children up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.*

Periodontal services

Periodontal scaling and root planing are limited to once per quadrant every 2 Calendar Years and are not covered if done within 24 months of periodontal surgical procedures in the same quadrant.

D4341 Periodontal scaling and root planing – four or more teeth per quadrant

D4342 Periodontal scaling and root planing – one to three teeth, per quadrant

D4910 Periodontal maintenance –*Periodontal maintenance is only covered when performed following active periodontal treatment and is limited to two treatments per Calendar Year in combination with routine prophylaxis.*

Prosthodontic services
Adjustment to denture and partial denture are limited to two per Calendar Year, at least 6 months after delivery of appliance.
D5410 Adjust complete denture – maxillary
D5411 Adjust complete denture – mandibular
D5421 Adjust partial denture – maxillary
D5422 Adjust partial denture – mandibular
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth – complete denture (each tooth)
D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth – per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
Replacement of all teeth and acrylic on cast metal framework is limited to once every five Calendar Years.
D5670 Replace all teeth and acrylic on cast metal framework, maxillary
D5671 Replace all teeth and acrylic on cast metal framework, mandibular
Rebase and reline of dentures is limited to a maximum of once every 3 Calendar Years after 6 months of initial placement.
D5710 Rebase complete maxillary denture
D5711 Rebase complete mandibular denture
D5720 Rebase maxillary partial denture
D5721 Rebase mandibular partial denture
D5730 Reline complete maxillary denture (chairside)
D5731 Reline complete mandibular denture (chairside)
D5740 Reline maxillary partial denture (chairside)
D5741 Reline mandibular partial denture (chairside)
D5750 Reline complete maxillary denture (laboratory)
D5751 Reline complete mandibular denture (laboratory)
D5760 Reline maxillary partial denture (laboratory)
D5761 Reline mandibular partial denture (laboratory) Rebase/Reline – *Limited to once in a 36-month period.*
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 Recement fixed partial denture – *Recement of crowns, fixed partial denture or onlays is limited to one per Calendar Year, after 6 months of initial placement.*
D6980 Fixed partial denture repair, by report – *Coverage determined by report. Charges submitted without report are not covered.*
Oral surgery
D7111 Extraction coronal remnants, deciduous tooth
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220 Removal of impacted tooth – soft tissue
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.
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Oral surgery - continued on next page

Oral surgery (cont.)
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 Surgical removal of residual tooth roots (cutting procedure)
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions – per quadrant
D7311 Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions – per quadrant
D7321 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess – intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7971 Excision of pericoronal gingiva
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Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible for this plan.
- The annual benefit maximum is $1,200 per covered person.
- Covered services shall include only those services specifically listed in Section 5, Dental Services and Supplies. A covered service must be incurred and completed while the person receiving the service is a covered person. Covered services are subject to plan provisions for exclusions and limitations and meet acceptable standards of dental practice as determined by us.
- For services listed with an asterisk (*), the choice of a lower cost treatment is available. If you or your dental 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 pre-authorization of benefits. GEHA will respond to a request to pre-authorize services with an estimate of covered service, which is not a guarantee of payment since future changes such as changes in your enrollment or eligibility under the dental plan may affect benefits. We encourage you to ask your provider to pre-authorize any extensive treatment. By pre-authorizing treatment, you and your dental provider will have an estimate before treatment begins of what will be covered and how it will be paid. This information can be valuable to you in making an informed decision on how to proceed with treatment and can help protect you from unexpected out-of-pocket costs should the treatment plan not be covered.
- To pre-authorize treatment, the dentist should submit a completed dental pre-authorization claim form that itemizes the proposed procedure codes, charge for each procedure along with pretreatment plan, X-rays and any other diagnostic materials.

You Pay:

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

Major restorative services
D0160 Detailed and extensive oral evaluation – problem focused, by report – *Detailed and extensive oral evaluations are limited to once per covered person per dentist, per lifetime.*
Replacement crowns, onlays, buildups and posts and cores are covered only 5 years after initial or prior placement unless required as a result of an Accidental Bodily Injury and satisfactory evidence is presented showing the crown, onlay, buildup or post and core cannot be made serviceable.
Crowns, onlays and posts and cores are payable only when required for restorative purposes and necessary due to decay or tooth fracture and evidence is presented showing the tooth cannot be adequately restored with a amalgam or composite filling.
D2542 Onlay – metallic – two surfaces
D2543 Onlay – metallic – three surfaces
D2544 Onlay – metallic – four or more surfaces
*D2642 Onlay – porcelain/ceramic, two surfaces
*D2643 Onlay – porcelain/ceramic, three surfaces
*D2644 Onlay – porcelain/ceramic, four or more surfaces
*D2662 Onlay – resin based composite, two surfaces
*D2663 Onlay – resin based composite, three surfaces
*D2664 Onlay – resin based composite, four or more surfaces
*D2710 Crown – resin based composite (indirect)
*D2712 Crown – 3/4 resin based composite (indirect)
*D2720 Crown – resin with high noble metal
*D2721 Crown – resin with predominantly base metal
*D2722 Crown – resin with noble metal
*D2740 Crown – porcelain/ceramic substrate
*D2750 Crown – porcelain fused to high noble metal
D2751 Crown – porcelain fused to predominately base metal
*D2752 Crown – porcelain fused to noble metal
*D2780 Crown – 3/4 cast high noble metal
D2781 Crown – 3/4 cast predominately base metal
*D2782 Crown – 3/4 cast noble metal
*D2783 Crown – 3/4 porcelain/ceramic
*D2790 Crown – full cast high noble metal
D2791 Crown – full cast predominately base metal
*D2792 Crown – full cast noble metal
*D2794 Crown – titanium
D2950 Core buildup, including any pins – *Core buildups are covered only when there is evidence presented showing insufficient retention for a crown.*
Posts are only covered when provided as part of a buildup for a crown. When performed as an independent procedure, the placement of a post is not covered.
*D2952 Cast post and core in addition to crown
*D2953 Each additional cast post – same tooth
D2954 Prefabricated post and core, in addition to crown
*D2957 Each additional prefabricated post – same tooth
D2980 Crown repair, coverage determined by report, charges submitted without reports are not covered
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Major restorative services - continued on next page

Major restorative services (cont.)

Not covered:

- *Gold foil restorations*
- *Sedative restorations*
- *Restorations for cosmetic purposes only*
- *Composite resin inlays*
- *Any exclusions or limitations listed under Section 7 of this plan document*

Endodontic services

D3310 Anterior root canal (excluding final restoration)

D3320 Bicuspid root canal (excluding final restoration)

D3330 Molar root canal (excluding final restoration)

Retreatment of root canal is covered only after 12 months from the prior root canal therapy.

D3346 Retreatment of previous root canal therapy – anterior

D3347 Retreatment of previous root canal therapy – bicuspid

D3348 Retreatment of previous root canal therapy – molar

D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)

D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)

D3353 Apexification/recalcification – final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)

D3410 Apicoectomy/periradicular surgery – anterior

D3421 Apicoectomy/periradicular surgery – bicuspid (first root)

D3425 Apicoectomy/periradicular surgery – molar (first root)

D3426 Apicoectomy/periradicular surgery (each additional root)

D3450 Root amputation – per root

D3920 Hemisection (including any root removal) – not including root canal therapy

Periodontal services

Gingivectomy, gingivoplasty, gingival flap procedure, guided tissue regeneration, soft tissue grafts, bone replacement grafts and osseous surgery are limited to once per quadrant every 2 Calendar Years.

D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces, per quadrant

D4211 Gingivectomy or gingivoplasty – one to three teeth, per quadrant

D4240 Gingival flap procedure, including root planing, four or more contiguous teeth or bounded teeth spaces per quadrant

D4249 Clinical crown lengthening – hard tissue

D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant

D4261 Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant

D4270 Pedicle soft tissue graft procedure

D4271 Free soft tissue graft procedure (including donor site surgery)

D4273 Subepithelial connective tissue graft procedures (including donor site surgery)

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis – *Limited to once per lifetime.*

D4381 Localized delivery of antimicrobial agents – *Coverage determined by review of report. Charges submitted without report are not covered.*

Prosthodontic services

Initial prosthodontic appliance (i.e. 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 date the person became a covered person.

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

D5110 Complete denture – maxillary

D5120 Complete denture – mandibular

D5130 Immediate denture – maxillary

D5140 Immediate denture – mandibular

D5211 Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)

D5212 Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)

D5213 Maxillary partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth)

D5214 Mandibular partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth)

D5281 Removable unilateral partial denture – one piece cast metal (including clasps and teeth)

D6210 Pontic – cast high noble metal

D6211 Pontic – cast predominately base metal

D6212 Pontic – cast noble metal

*D6214 Pontic – titanium

D6240 Pontic – porcelain fused to high noble metal

D6241 Pontic – porcelain fused to predominately base metal

D6242 Pontic – porcelain fused to noble metal

D6245 Pontic – porcelain/ceramic

D6519 Inlay/onlay – porcelain/ceramic

D6520 Inlay – metallic – two surfaces

D6530 Inlay – metallic – three or more surfaces

D6543 Onlay – metallic – three surfaces

D6544 Onlay – metallic – four or more surfaces

D6545 Retainer – cast metal for resin bonded fixed prosthesis

D6548 Retainer – porcelain/ceramic for resin bonded fixed prosthesis

D6740 Crown – porcelain/ceramic

D6750 Crown – porcelain fused to high noble metal

D6751 Crown – porcelain fused to predominately base metal

D6752 Crown – porcelain fused to noble metal

D6780 Crown – 3/4 cast high noble metal

D6781 Crown – 3/4 cast predominately base metal

D6782 Crown – 3/4 cast noble metal

Prosthodontic services - continued on next page

Prosthodontic services (cont.)
D6783 Crown – 3/4 porcelain/ceramic
D6790 Crown – full cast high noble metal
D6791 Crown – full cast predominately base metal
D6792 Crown – full cast noble metal
*D6794 Crown – Titanium
D6972 Prefabricated post and core in addition to fixed partial denture retainer
D6973 Core buildup for retainer, including any pins
Adjunctive general services
Sedation/Anesthesia - Deep sedation/general anesthesia and intravenous conscious sedation are covered only when provided in connection with a covered procedure(s) and when determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions. To be covered, the procedure for which deep sedation/general anesthesia and intravenous conscious sedation was provided must be submitted along with a report of why anesthesia was necessary. Charges submitted without a report will be denied as non-covered benefits.
D9220 Deep sedation/general anesthesia – first 30 minutes
D9221 Deep sedation/general anesthesia – each additional 15 minutes
D9241 Intravenous conscious sedation/analgesia – first 30 minutes
D9242 Intravenous conscious sedation/analgesia – each additional 15 minutes
D9610 Therapeutic drug injection, by report – *Therapeutic drug injections are not covered if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication. Charges submitted without a report will be denied as non-covered benefits.*
D9930 Treatment of complications (post-surgical) unusual circumstances, by report – *Coverage determined by review of report. Charges submitted without report are not covered.*
D9940 Occlusal guard, by report – *Occlusal guards are limited to once per Calendar Year for covered persons age 13 or older and only when the purpose of the occlusal guard is for the treatment of bruxism or diagnosis other than temporomandibular joint dysfunction. Charges submitted without a report will be denied as non-covered benefits.*
D9941 Fabrication of athletic mouthguard – *Limited to once per covered person per Calendar Year.*
D9974 Internal bleaching – per tooth – *Internal bleaching of discolored teeth is covered for endodontically treated anterior teeth once per covered person per tooth every 3 calendar years. External bleaching of discolored teeth is not a covered benefit.*
Not covered: • *Precision attachments, personalization, precious metal bases, and other specialized techniques* • *Replacement of dentures that have been lost, stolen or misplaced* • *Removable or fixed prostheses initiated prior to the effective date of coverage or inserted/cemented after the coverage ending date* • *Any exclusions or limitations listed under Section 7 of this plan document*
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Class D Orthodontic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible for this plan.
- The annual benefit maximum is $1,200 per covered person. There is a lifetime maximum benefit of $1,500 per covered child for Class D covered services.
- There is a 24-month waiting period for Class D benefits.
- 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 less than age 19.
- Covered services shall include only those services specifically listed in Section 5, Dental Services and Supplies. A covered service must be incurred and completed while the person receiving the service is a covered person. Covered services are subject to plan provisions for exclusions and limitations and meet acceptable standards of dental practice as determined by us.
- For services listed with an asterisk (*), the choice of a lower cost treatment is available. If you or your dental practitioner should choose this treatment or service, we will allow the lower cost alternative benefit unless evidence is submitted with the bill to explain why the less expensive treatment could not be done.
- Covered services are limited to the maximum allowable charge as determined by us and are subject to alternative benefit, coinsurance, maximum benefit limits, waiting period and the other limitations described in this plan document.
- The plan does not require predetermination of benefits. GEHA will respond to a request to pre-authorize services with an estimate of covered service, which is not a guarantee of payment since future changes such as changes in your enrollment or eligibility under the plan may affect benefits. We encourage you to ask your provider to pre-authorize any extensive treatment. By pre-authorizing treatment, you and your dental provider will have an estimate before treatment is started of what will be covered and how it will be paid. This information can be valuable to you in making an informed decision on how to proceed with treatment and can help protect you from unexpected out-of-pocket costs should the treatment plan not be covered.
- To pre-authorize treatment, the dentist should submit a completed dental predetermination claim form that itemizes the proposed procedure codes, charge for each procedure along with pretreatment plan, X-rays and any other diagnostic materials.

You pay:

- ***High Option***
  - **In-network:** 70 % of plan allowance.
  - **Out-of-network:** 70 % of plan allowance and any difference between our allowance and the billed amount.
- ***Standard Option***
  - **In-network:** 70 % of plan allowance.
  - **Out-of-network**: 70 % of plan allowance and any difference between our allowance and the billed amount.

Orthodontic services – limited to children up to age 19

Initial payment for orthodontic treatment will not be made until the banding date has been submitted to us.

Orthodontic treatment is not covered if the initial placement of the bands on the teeth was made prior to the dependent child becoming a covered child.

Charges will be considered, subject to other plan conditions, as follows:

- *The total case fee 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.*
- *Verification that the covered child is still receiving active treatment is required from the provider once every 3 months.*

D8010 Limited orthodontic treatment of the primary dentition

D8020 Limited orthodontic treatment of the transitional dentition

D8030 Limited orthodontic treatment of the adolescent dentition

D8050 Interceptive orthodontic treatment of the primary dentition

D8060 Interceptive orthodontic treatment of the transitional dentition

D8070 Comprehensive orthodontic treatment of the transitional dentition

D8080 Comprehensive orthodontic treatment of the adolescent dentition

D8090 Comprehensive orthodontic treatment of the adult dentition

D8210 Removable appliance therapy

D8220 Fixed appliance therapy

D8660 Pre-orthodontic treatment visit

D8670 Periodic orthodontic treatment visit (as part of contract) – *When part of the contract, a periodic orthodontic treatment visit is considered part of complete orthodontic treatment plan and not reimbursable as a separate service.*

D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)

D8690 Orthodontic treatment (alternative billing to a contract fee) - *Orthodontic treatment (alternative billing to a contract fee) will be reviewed for individual consideration and is only considered when services are rendered by a dentist other than the dentist rendering complete orthodontic treatment.*

Not covered:

- *Repair of damaged orthodontic appliances*
- *Replacement of lost or missing appliance*
- *Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.*
- *Any exclusions or limitations listed under Section 7 of this plan document*

Section 6 International Services and Supplies

International Claims Payment

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

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

Finding an International Provider

GEHA's CONNECTION Dental Network extends into Puerto Rico and Guam. GEHA has a dedicated email address for our members outside the United States: overseas.gehadental@geha.com.

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

Filing International Claims

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

Customer Service Website and Phone Numbers

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

International Rates

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

Section 7 General Exclusions – Things We Do Not Cover

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

We do not cover the following:

- Any dental service or treatment not specifically listed as a covered service.
- Services or treatment for the provision of an initial prosthodontic appliance (i.e. 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 and temporary dentures, appliances, devices, X-rays and services.
- Experimental services or treatment not generally recognized by the dental profession as necessary for treatment of the condition or for which there is no reasonable expectation of effective treatment.
- Services or treatment provided for oral hygiene instruction or dietary counseling for the control of dental caries and plaque.
- Services or treatment provided by or paid for by any government or government employed dental practitioner, unless the covered person is legally required to pay for such services or supplies.
- Services or treatment for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the law or regulation of any governmental unit. This exclusion applies whether or not you claim the benefit or compensation.
- Congenital malformations.
- Repair or replacement of orthodontic appliance.
- Services or treatment provided primarily for cosmetic purposes.
- Services or treatment provided by a member of your immediate family or a member of the immediate family of your spouse.
- Any treatment not prescribed or performed by a licensed physician or dental practitioner.
- Services or treatment for which no charge would be made in absence of this coverage.
- Services or treatment resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization.
- Services or treatment provided as a result of intentionally self-inflicted injury or illness.
- Services or treatment provided as a result of injuries suffered while: committing or attempting to commit a felony; engaging in an illegal occupation; or participation in a riot, rebellion or insurrection.
- Office infection control.
- 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, 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.
- Services rendered after the termination of coverage, except under elected continuation 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.
- Nitrous oxide.
- Oral sedation.
- Precision dentures or characterization or personalization of crowns, dentures or fillings.
- Gold foil restorations.
- Services or treatments that are necessary due to patient failure to follow the dental practitioner's instructions.
- Services or treatments that are not the least costly alternative that accomplishes a result that meets accepted standards of professional dental care as determined by us.
- Any service or treatment that is part of the complete dental procedure is considered a component of, and is included in, the fee for the complete procedure.
- Services received from a dental or medical department maintained by or on behalf of any employer, mutual benefit association, labor union, trust or similar person or group.
- Services performed by a dentist who is compensated by a facility for similar covered services performed for members.
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
- Service or care required as a result of complications from a treatment or service not covered under the plan.
- Fraudulent claims for service.
- Claims submitted later than December 31 of the calendar year following the one in which the expense was incurred, except when the member was legally incapable.
- State or territorial taxes on dental services performed.
- Adjunctive dental services as defined by applicable federal regulations. The Federal dental program does not cover adjunctive dental care services. These are medical services that are covered by other medical insurance even when provided by a general dentist or oral surgeon. The following diagnoses or conditions may fall under this category:
  - Treatment for relief of myofacial pain dysfunction syndrome or temporomandibular joint dysfunction (TMJD).
  - Orthodontic treatment for cleft lip or cleft palate, or when required in preparation for, or as a result of, trauma to teeth and supporting structures caused by medically necessary treatment of an injury or disease.
  - Procedures associated with preventative and restorative dental care when associated with radiation therapy to the head or neck unless otherwise covered as a routine preventative procedure under this plan.
  - Total or complete ankyloglossia.
  - Intraoral abscesses that extend beyond the dental alveolus.
  - Extraoral abscesses.
  - Cellulitis and osteitis, which is clearly exacerbating and directly affecting a medical condition currently under treatment.
- Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.
- Prosthetic replacement of either the maxilla or mandible due to reduction of body tissues associated with traumatic injury (such as a gun shot wound) in addition to services related to treating neoplasms or iatrogenic dental trauma.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

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

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

For out-of-network provider claims, if you are a GEHA Health Plan member, send dental claims to:

GEHA Connection Dental Federal

P.O. Box 2336

Independence, MO 64051-2336

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

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

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

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

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

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

Keep a separate record of the dental expenses of each covered person, as maximum benefit limits apply separately to each covered person. Save copies of all dental bills. In most instances, they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

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.

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

International Claims

For covered services you receive outside of the United States and Puerto Rico, send itemized bills that include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred. If possible, include a receipt showing the exchange rate on the date the claimed services were performed. All international claims should be submitted to GEHA, Foreign Dental Claims Department, P.O. Box 2336, Independence, MO 64051-2336.

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Deadline for Filing Your Claim

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

We may, at our option, require supporting documentation such as clinical reports, charts, X-rays and study models.

Disputed Claims Process

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

Disputed Claim Steps:

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

- Write to us within 6 months from the date of our decision; and
- Send your request to us at: GEHA Connection Dental Federal, P. O. Box 455, Independence, MO 64051-0455; and
- Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

Include copies of documents that support your claim, such as dentist's letters, provider narratives, X-rays or other records, and explanation of benefits (EOB) forms.

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

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

3 If you do not agree with our final decision, you may request an independent third party, mutually agreed upon by us and OPM, to review the decision.

The decision of the independent third party is binding on us and is the final administrative review of your claim. To request an independent third-party review you must:

- Write to us within 90 days of our letter maintaining denial; and
- Send your request to us at: GEHA Connection Dental Federal, P. O. Box 455, Independence, MO 64051-0455; and

Include a statement about why you are requesting an independent third-party review. This statement should include why you believe our decision to deny your claim was wrong, based on specific benefit provisions in this brochure; and include copies of documents that support your claim, such as dentist's letters, provider narratives, X-rays or other records, and explanation of benefits (EOB) forms.

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

Section 9 Definitions of Terms We Use in This Brochure

Accidental Bodily Injury	Accidental bodily injury is an injury caused by an external force or element, such as a blow or fall and that requires immediate attention. Accidental bodily injury will not include any injuries sustained as a result of a chewing incident, regardless of the condition of the tooth or teeth at the time of the chewing incident.
Adjunctive Dental Care	Dental care that is: • Medically necessary in the treatment of an otherwise covered medical (not dental) condition. • An integral part of the treatment of such medical condition. • Essential to the control of the primary medical condition. • Required in preparation for or as the result of dental trauma, which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).
Annual Benefit Maximum	The maximum annual benefit that you can receive per person each calendar year.
Annuitants	Federal retirees (who retired on an immediate annuity) and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Calendar Year	The period of time that starts January 1 and ends December 31 of each year. For any covered person who first becomes covered after January 1 of any year, a calendar year shall be deemed to be the continuous period of time between the date coverage became effective and December 31 of that year.
Class A Services	Basic services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and X-rays.
Class B Services	Intermediate services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
Class C Services	Major services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
Class D Services	Orthodontic services.
Coinsurance	Coinsurance is the stated percentage of covered expenses you must pay.
Copay/Copayment	A copayment is a fixed amount of money you pay to the provider when you receive services. Example: When you see your PPO provider, under the Standard Option, you pay a copayment of $10 for a Class A service visit.
Cosmetic Procedure	A cosmetic procedure is any procedure or portion of a procedure performed primarily to improve physical appearance or is performed for psychological purposes.
Covered Child	A covered child is defined for purposes of Class D covered services as a child less than age 19.

Covered Provider	A covered provider is any licensed dentist, dental hygienist or denturist acting within the scope of such license.
Covered Service	Covered services shall include only those services specifically listed in Section 5, Dental Services and Supplies. A covered service must be incurred and completed while the person receiving the service is a covered person. Covered services are subject to plan provisions for exclusions and limitations and meet acceptable standards of dental practice as determined by us.
Enrollee	The Federal employee or annuitant enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Generally Accepted Dental Protocols	Services that are necessary for the treatment of a condition, for which there is reasonable expectation of effective treatment and billed according to guidelines described in the Current Dental Terminology (CDT) guide of dental procedures and nomenclature by the American Dental Association (ADA).
Incur/Incurred	A covered service is deemed incurred on the date care, treatment or service is received.
Maximum Allowable Charge	Maximum allowable charge means the maximum amount allowed by the dental plan for covered services. The maximum allowable charge is based on the general level of charges accepted by other providers in the area for like treatment, procedure or services. Our determination of what is allowable is final for the purpose of determining benefits payable under the dental plan.
Missing Tooth Clause	The exclusion of any service or supply rendered to replace a tooth lost prior to the effective date of coverage.
Plan Allowance	The amount we use to determine our payment for out-of-network services.
Pre-Authorization	This is the procedure used by the plan to estimate covered services and the amount that the plan will cover. It is not a guarantee of payment.
Preexisting Condition	Any disease or condition of the teeth or supporting structures which were present on the effective date of coverage.
Provider Change	If you change from one provider to another during the course of treatment, or if more than one provider performs the same covered service, we will provide the same amount of benefits as if there had been only one provider involved in your treatment.
Service Dates	For benefit determination purposes, we will use these dates as completion dates for the following covered services: • Full or partial denture: the date the completed appliance is first inserted in the mouth. • Inlay, onlay, crown or fixed bridge including, but not limited to, a Maryland bridge: the date the appliance is permanently cemented in place. • Root canal therapy: the date the canal is permanently filled. • Periodontal surgery: the date the surgery is actually performed. • Any other service: the date the service is actually performed.
Waiting Period	Waiting period for covered services means the period of time between the date a member or eligible dependent is first covered under a GEHA dental plan and the date dental services are covered. Applies only to orthodontic services in GEHA's dental plan options.
We/Us	GEHA Connection Dental Federal.
You	Enrollee or eligible family member.

Non-FEDVIP Benefits

The services on this page are not part of the FEDVIP contract or premium; **you cannot file a FEDVIP disputed claim regarding these services.** Fees you pay for these services do not count toward FEDVIP deductibles or maximum out-of-pocket benefits.

Connection's Avesis Vision: (800) 672-7552, www.Avesis.com

Free to all GEHA Connection Dental Federal plan option members, Connection's Avesis Vision® offers a $25 copay on eye exams at participating in-network Avesis locations and up to a $25 reimbursement benefit at non-participating out-of-network locations. GEHA offers this program through Avesis Vision Care Plan. File Out-of-Network claims to:

Avesis Third Party Administrators, Inc.

Vision Claims Department

P. O. Box 7777

Phoenix, AZ 85011-7777

At participating Avesis locations, GEHA members also receive discounts off the retail price of lenses, frames, specialty items such as tints, lightweight plastics, scratch-resistant coatings, contact lenses and surgical procedures (including LASIK). For a list of participating locations, go to www.Avesis.com or call (800) 672-7552.

CONNECTION Hearing by HearPO: (888) HEARING (432-7464), www.HEARPO.com

Free to all GEHA Connection Dental Federal plan option members, CONNECTION Hearing® by HearPO offers cost savings on hearing aids and other hearing health needs at more than 4,800 credential hearing aid providers. The program provides testing, substantial discounts on all styles of hearing aids, programmable and digital hearing aids, discounts on repairs, and a 60-day trial period with a money-back guarantee. Program benefits are available to all GEHA Connection Dental Federal Plan members, covered dependents, and parents and grandparents of members and spouses. Call the toll-free number to receive a written referral to a provider in your area.

Stop Health Care Fraud!

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

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

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

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

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

You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the plan.

Summary of Benefits

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

High Option Benefits	You Pay In-network	You Pay Out-of-network	Page
Class A (Basic) Services – preventative and diagnostic	Nothing	Any difference between the plan allowance and the billed amount.	14
Class B (Intermediate) Services – includes minor restorative services	20%	20% of the plan allowance and any difference between our allowance and the billed amount.	16
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	50%	50% of the plan allowance and any difference between our allowance and the billed amount.	20
Class A, B, and C Services are subject to a $1,200 annual maximum benefit			
Class D Services – orthodontic $1,500 Lifetime Maximum	70%	70% of the plan allowance and any difference between our allowance and the billed amount.	25

Standard Option Benefits	You Pay In-network	You Pay Out-of-network	Page
Class A (Basic) Services – preventative and diagnostic	$10 copay	$10 copay per visit and any difference between the plan allowance and the billed amount.	14
Class B (Intermediate) Services – includes minor restorative services	45%	45% of the plan allowance and any difference between our allowance and the billed amount.	16
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	65%	65% of the plan allowance and any difference between our allowance and the billed amount.	20
Class A, B, and C Services are subject to a $1,200 annual maximum benefit			
Class D Services – orthodontic $1,500 Lifetime Maximum	70%	70% of the plan allowance and any difference between our allowance and the billed amount.	25

Rate Information

How to find your rate

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

Premium Rating Areas by State/ZIP Code (first three digits)							
AK entire state	5	IN 460-462	2	NC entire state	2	SC entire state	2
AL entire state	1	IN 463,464	3	ND entire state	1	SD entire state	1
AR entire state	1	IN rest of state	1	NE entire state	1	TN entire state	2
AZ entire state	3	KS 660-662	2	NH entire state	4	TX 750-753, 760-762	3
CA 939-941, 943-954	5	KS rest of state	1	NJ 080-084	3	TX 770-775	3
CA rest of state	4	KY 410	2	NJ rest of state	5	TX rest of state	2
CO entire state	4	KY rest of state	1	NM	3	UT entire state	1
CT 064-069	5	LA entire state	2	NV 897	4	VA 201, 220-226	4
CT rest of state	4	MA entire state	4	NV rest of state	3	VA rest of state	2
DC entire state	4	MD 206-218	4	NY 004, 005, 100-119	5	VT entire state	2
DE entire state	3	MD 219	3	NY 124-126	5	WA 980-985	5
FL 330-334	4	MD rest of state	2	NY rest of state	2	WA 986	3
FL rest of state	2	ME entire state	3	OH 440-443, 430-432	2	WA rest of state	4
GA 300-303, 311	3	MI 480-485	3	OH 450-455	2	WI 540	3
GA rest of state	2	MI rest of state	2	OH rest of state	1	WI rest of state	2
HI entire state	3	MN 550-555	3	OK entire state	2	WV entire state	2
IA entire state	1	MN rest of state	2	OR entire state	3	WY entire state	1
ID entire state	2	MO 630-633, 640, 641	2	PA 183	5	PR entire territory	1
IL 600-608	3	MO rest of state	1	PA 189, 190-194	3	GU entire territory	1
IL 620-622	2	MS entire state	1	PA rest of state	1	VI entire territory	1
IL rest of state	1	MT entire state	2	RI entire state	4	FO & any other area	1

Monthly Rates

Rating Area	High Option Self Only	High Option Self Plus One	High Option Self and Family	Standard Option Self Only	Standard Option Self Plus One	Standard Option Self and Family
1	**$28.30**	**$56.59**	**$84.89**	**$20.30**	**$40.63**	**$60.93**
2	**$31.07**	**$62.10**	**$93.17**	**$22.25**	**$44.48**	**$66.73**
3	**$35.14**	**$70.31**	**$105.45**	**$25.18**	**$50.33**	**$75.51**
4	**$37.90**	**$75.81**	**$113.71**	**$27.13**	**$54.25**	**$81.38**
5	**$42.03**	**$84.05**	**$126.08**	**$30.05**	**$60.10**	**$90.16**
International	**$28.30**	**$56.59**	**$84.89**	**$20.30**	**$40.63**	**$60.93**

Bi-weekly Rates

Rating Area	High Option Self Only	High Option Self Plus One	High Option Self and Family	Standard Option Self Only	Standard Option Self Plus One	Standard Option Self and Family
1	$13.06	$26.12	$39.18	$9.37	$18.75	$28.12
2	$14.34	$28.66	$43.00	$10.27	$20.53	$30.80
3	$16.22	$32.45	$48.67	$11.62	$23.23	$34.85
4	$17.49	$34.99	$52.48	$12.52	$25.04	$37.56
5	$19.40	$38.79	$58.19	$13.87	$27.74	$41.61
International	$13.06	$26.12	$39.18	$9.37	$18.75	$28.12