GEHA Connection **Vision**

Powered by EyeMed

GEHA®

Connection Vision Plan Powered by EyeMed Vision Care

This brochure describes the Connection Vision Plan ("The Vision Plan") benefits that are part of the Government Employees Health Association, Inc. Voluntary Welfare Benefit Plan ("Plan"). The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA). This brochure constitutes not only the Summary Plan Description required by ERISA Section 102, but is incorporated into and forms part of the actual Plan Document, written in a manner so that it can readily be understood and used by You and by GEHA in administering The Vision Plan.

Contact Information:
Customer Service - (877) 808-8538
Participating Providers - (877) 808-8538
Website – www.EyeMed.com

File claims to:
EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Locate a participating provider – Call EyeMed at (877) 808-8538 or go to www.EyeMed.com

Definitions

Child - Child includes only:

- Your natural child or adopted child; and
- Your stepchild, grandchild or other child who lives with you in a regular parent-child relationship and for whom you (or your spouse who lives with you) have custody.

Covered Person - A Covered Person means a Member or Eligible Dependent who is covered by any of the following plans:

- GEHA Health Plan, High and Standard Option
- GEHA Health Plan High Deductible Health Plan
- GEHA Health Plan Elevate and Elevate Plus
- GEHA Connection Dental *Plus*
- GEHA Connection Dental Federal, High and Standard Option

Eligible Dependent - An Eligible Dependent is:

- Your legally married spouse; and
- Each Child who is determined eligible as defined by the GEHA plan of which you are a member.

Eligible Person - An Eligible Person is:

- Any federal employee or annuitant who is enrolled in High Option, Standard Option or High Deductible Health Plan of the GEHA health plan under the Federal Employees Health Benefits Program (FEHB); or
- Any federal employee or annuitant who is enrolled in Elevate or Elevate Plus of the GEHA health plan under the Federal Employees Health Benefits Program (FEHB); or
- Any federal employee or annuitant who is enrolled in the GEHA Connection Dental *Plus* Plan; or
- Any federal employee or annuitant who is enrolled in the GEHA Connection Dental Federal Plan under the Federal Employees Dental and Vision Insurance Program (FEDVIP); or
- A member of a special class of membership that GEHA may establish from time to time.

Enrollment Period - The Enrollment Period is the time period that begins with you or your Dependent(s)' Eligibility Date and ends when you are no longer an Eligible Person.

GEHA - Government Employees Health Association, Inc.

Optical Practitioner - Any licensed optometrist, ophthalmologist or optician acting within the scope of such license.

General Information

Name of the Plan
The Vision Plan shall be known as the Government Employees Health Association, Inc. Connection Vision powered by EyeMed, which is part of the Government Employees Health Association, Inc. Voluntary Welfare Benefit Plan.

Type of Administrator
Benefits administered by EyeMed Vision Care LLC.; Underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York.

Address of Plan
GEHA Connection Vision powered by EyeMed.
310 NE Mulberry Street
Lee's Summit, MO 64086

Agent for Service of Legal Process
GEHA
c/o Belinda Thompson 310 NE Mulberry
Lee's Summit, MO 64086-5861 (816) 257-5500
Service of Legal Process may also be made upon the Plan Administrator.

Plan Number 601

EyeMed Plan Number 9787961
EyeMed Plan Number 9787979
Plan Effective Date January 1, 2011

EyeMed Plan Number 1023962
EyeMed Plan Number 1023963
Plan Effective Date January 1, 2020

Plan Renewal Date January 1

Plan Year End December 31

Plan Sponsor and its IRS Employer Identification Number:
Government Employees Health Association, Inc.
310 NE Mulberry Street
Lee's Summit, MO 64086
EIN 44-0545275

Plan Administrator
GEHA
310 NE Mulberry Street
Lee's Summit, MO 64086
(816) 257-5500

Type of Plan
Welfare plan including vision benefits

Contributions
Contributions are made by GEHA

Funding Medium

The Plan is funded through an insurance policy purchased from:
EyeMed Vision Care LLC
4000 Luxottica Place
Mason, OH 45040
(877) 808-8538

Named Fiduciary and Contact Information
Government Employees Health Association
310 NE Mulberry Street
Lee's Summit, MO 64086
(816) 257-5500

The Government Employees Health Association, Inc. Connection Vision Plan powered by EyeMed Vision Care is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA). We intend to maintain The Vision Plan indefinitely. However, we have the right to modify or terminate The Vision Plan at any time, and for any reason, as to any part or in its entirety, without advance notice. If The Vision Plan is amended or terminated, you will not receive benefits described in the vision brochure after the effective date of such amendment or termination. Any such amendment or termination shall not affect your right to benefits for claims incurred prior to such amendment or termination. If The Vision Plan is amended, you may be entitled to receive different benefits or benefits under different conditions. However, if The Vision Plan is terminated, all benefit coverage would end. This may happen at any time, and in no event will you become entitled to any vested rights under The Vision Plan.

You are entitled to this coverage if the provisions in the vision brochure have been satisfied. This vision brochure is void if you have ceased to be entitled to coverage. No clerical error will invalidate your coverage if otherwise validly in force. Oral statements cannot modify the benefits described in this brochure.

General Provisions

Choice of Vision Practitioner - Each Covered Person has the right to choose any licensed Optical Practitioner. If you use a Participating EyeMed Provider, you will pay the Copay noted in the Benefit Schedule found in this booklet. If you use a non-participating provider, you will need to submit the claim to receive a reimbursement of up to the out-of-network amount shown in the Benefit Schedule. See How to File Claims section in this brochure.

Premium – The full cost will be handled by GEHA for Eligible Members and Eligible Dependents who are actively covered by the GEHA Heath Plan High or Standard Option, GEHA Connection Dental *Plus,* GEHA Connection Dental Federal, and/or the GEHA Employee Benefit Plan. Members who elect COBRA continuation of coverage will pay the full COBRA premiums. GEHA reserves the right to charge a Premium to Eligible Members and Eligible Dependents in the future.

When Coverage Begins

Eligibility Date
You are eligible for coverage on the date you are an Eligible Person as a member of the Government Employees Health Association.
Your Eligible Dependent(s) will be eligible for coverage on the later of:

- Your Eligibility Date; or
- The date the Dependent first becomes an Eligible Dependent.

If an Eligible Dependent is also an Eligible Member, he or she will be eligible for coverage as a Member or as a Dependent, but not as both.

Medical Child Support Orders, typically issued in divorce proceedings, may create or recognize the right of a child of a Member to be covered under The Vision Plan. Such an order must be qualified under federal law for The Vision Plan to be bound by it. Please contact the Claims Department for a free copy of our guidelines used to determine whether a Medical Child Support Order is qualified

Enrollment Requirements
Your enrollment will be automatic for yourself and your Eligible Dependent(s) after your Eligibility Date by becoming a member in the following Government Employees Health Association plan(s):

- GEHA Health Plan High Option; and/or,
- GEHA Health Plan Standard Option; and/or
- GEHA Health Plan High Deductible Option; and/or
- GEHA Health Plan Elevate Option; and/or
- GEHA Health Plan Elevate Plus Option; and/or
- GEHA Connection Dental Federal Plan; and/or
- GEHA Connection Dental *Plus* Plan.

Effective Date of Coverage
If all Enrollment Requirements are met, then you or your Dependent(s)' coverage will be effective on the first day of your GEHA health or dental plan coverage. Coverage for any Eligible Dependent(s) will become effective only on or after your Effective Date of Coverage. All Eligible Dependents enrolled more than 31 days after your Eligibility Date will have a separate Effective Date of Coverage. An Eligible Person or Dependent shall become a Covered Person on the date coverage for such person begins.

When Coverage Terminates

Member - Your coverage will terminate on the date you no longer are eligible as a Covered Person.

Dependents - Your covered Dependent(s)' coverage under The Vision Plan will end on the earliest of the following dates:

- The date your coverage under The Vision Plan terminates;
- The date The Vision Plan is amended so as to terminate the Dependent(s)' coverage;
- The date on which the Dependent ceases to be an Eligible Dependent.

Termination Does Not Affect Existing Claims
When a Covered Person's coverage is terminated for any reason other than Involuntary Termination for Fraudulent Claims, such termination does not affect any claims for Covered Services that were incurred and completed while the Covered Person's coverage was in force (assuming any required Premium has been paid).

Involuntary Termination for Fraudulent Claims
If any Covered Person knowingly submits or participates in the submission of information that contains false or misleading facts, then we have the right to revoke that Covered Person's coverage.

Rights of a Covered Person

As a participant in The Vision Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

- Examine, without charge, at our office all Plan Documents, including contracts, bargaining agreements and copies of all documents filed by The Vision Plan with the U.S. Department of Labor, such as plan descriptions (filed before 1997) and annual reports;
- Obtain copies of all Vision Plan documents, including copies of the latest annual report and updated summary plan description, and other information upon written request to us. We will make a reasonable charge for copies;
- Receive a summary of The Vision Plan's annual financial report (if applicable). We are required by law to furnish each participant with a copy of this summary financial report; and

- File suit in a federal court, if certain plan materials requested are not received within thirty (30) days of your request, unless the materials were not sent because of matters beyond our control. The court may require The Vision Plan to pay up to $110 for each day's delay until the materials are received.

In addition to creating rights for participants, ERISA imposes obligations upon the persons who are responsible for the operation of The Vision Plan. These persons are referred to as "Fiduciaries" in the law. Fiduciaries must act solely in the interest of the participants and they must exercise prudence in the performance of their duties. Fiduciaries who violate ERISA may be removed and required to make good on any losses they have caused The Vision Plan.

No one may fire you or otherwise discriminate against you to prevent you from obtaining benefits under The Vision Plan or exercising your rights under ERISA.

If your claim for benefits is denied or ignored in full or in part, you have the right to know why this was done, to obtain free copies of documents relating to the decision and to appeal the denial. You also have the right to file suit in a federal or state court, if you have exhausted the claims procedures available to you under the Plan. In addition, if you disagree with The Vision Plan's decision about the qualified status of a medical child support order, you may file suit in federal court.

If Plan Fiduciaries are misusing The Vision Plan's money, or if you are discriminated against for asserting your rights, you have the right to file suit in federal court or request assistance from the U.S. Department of Labor. If you are successful in the lawsuit, the court may, if it so decides, require the other party to pay legal costs, including any attorney fees. If you are unsuccessful in the lawsuit, the court may, if it so decides, require you to pay the other party's legal costs and fees if, for example, the court decides the lawsuit is frivolous.

If you have any questions about this statement of your rights under ERISA, contact The Association or the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the phone book, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also get publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

You may continue coverage for yourself, spouse or dependent if there is a loss of coverage as a result of a Qualifying Event. You or your dependents will have to pay for such coverage. Review this plan brochure and the documents covering the plan on the rules governing your COBRA Continuation of Coverage rights.

Continuation of Coverage

The right to COBRA Continuation of Coverage was created by a federal law called the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your Vision Plan coverage. It can also become available to Eligible Dependents who are covered under the Plan when they would otherwise lose their Vision Plan coverage.

COBRA Continuation of Coverage is a continuation of The Vision Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA Continuation of Coverage must be offered to each person who is a "qualified beneficiary". You and your Eligible Dependents could become qualified beneficiaries if coverage under The Vision Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA Continuation of Coverage.

If COBRA continuation is elected, coverage will continue as though the qualifying event had not occurred. Any benefits paid prior to the qualifying event will be retained. If any changes are made to the coverage for the Member, the coverage provided to Covered Persons under this continuation provision will be similarly changed.

Qualifying Events
Continuation is available to Covered Persons in the event of the following Qualifying Event:

- A Member is no longer an Eligible Person, unless such loss of eligibility is due to gross misconduct.

Continuation shall also be available to a covered Eligible Dependent in the event of any one of the following Qualifying Events:

- A Member's death;
- Member is no longer an Eligible Person, unless such loss of eligibility is due to gross misconduct;
- Divorce or legal separation from a Member. If a member reduces or eliminates coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for the Eligible Dependent spouse even though his or her coverage was reduced or eliminated before the divorce or separation;
- A Dependent Child ceasing to qualify as a Dependent Child; and
- A Member's entitlement to Medicare.

You Must Give Notice of Qualifying Events
The Vision Plan will offer COBRA Continuation of Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. **You are responsible for notifying The Vision Plan of any qualifying event and to provide The Vision Plan with all information needed to meet its obligation to provide continuing coverage.** Your employer or payroll office will not notify The Vision Plan when a Qualifying Event occurs. You must provide this notice to the GEHA within 60 days after the qualifying event occurs by sending written notice to:

Connection Vision Contract Administrator
P. O. Box 21542
Eagan, MN 55121-9930

How COBRA Coverage is provided
Once GEHA receives notice from you that a qualifying event has occurred, COBRA Continuation of Coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA Continuation of Coverage. Covered Members may elect COBRA Continuation of Coverage on behalf of their Eligible Dependents.

Period of Continuation Coverage for Member
A Member who qualifies for COBRA Continuation of Coverage because he or she is no longer an Eligible Person may elect COBRA Continuation of Coverage for up to eighteen (18) months measured from the date of the Qualifying Event.

Period of Continuation Coverage for Covered Eligible Dependents
If a Covered Eligible Dependent elects COBRA Continuation of Coverage because the Member is no longer an Eligible Person, coverage may be continued for up to eighteen (18) months measured from the date of the Qualifying Event. Coverage may be continued for all other Qualifying Events for up to thirty-six (36) months.

Extension of COBRA Continuation Period for Disabled Members
The period of continuation shall be extended to twenty-nine (29) months in total (measured from the date of the Qualifying Event) in the event the Member is disabled (as determined by the Social Security Administration) within sixty (60) days after the date of the Qualifying Event.

The disability extension is available only if the Member notifies The Vision Plan in writing of the Social Security Administration's determination of disability within 60 days after the latest of: (1) the date of the Social Security Administration's disability determination; or (2) the date of the Qualifying Event. In addition, notice must be provided prior to the expiration of the initial eighteen (18) months of continuation coverage. If a second Qualifying Event occurs during the eleven (11) month disability extension explained herein, coverage may be continued for a maximum of thirty-six (36) months from the date of the first Qualifying Event. The second Qualifying Event must be a Qualifying Event that entitles continuation for thirty-six (36) months. In such event, we may charge the Covered Person up to 150% of the cost of the coverage for all months after the eighteenth (18th) month of continuation coverage, if (1) continuation coverage would not be available in the absence of a disability extension, and (2) the disabled qualified beneficiary is included in the coverage.

Extension of COBRA Continuation Period for Disabled Dependents

The period of continuation shall be extended to twenty-nine (29) months in total (measured from the date of the Qualifying Event) in the event the Eligible Dependent is disabled (as determined by the Social Security Administration) within sixty (60) days after the date of the Qualifying Event. The disability extension is available only if the individual notifies The Vision Plan in writing of the Social Security Administration's determination of disability within 60 days after the latest of: (1) the date of the Social Security Administration's disability determination; (2) the date of the Qualifying Event; and (3) the date on which the qualified beneficiary loses or would lose coverage under the terms of the Plan as a result of the Qualifying Event. In addition, notice must be provided prior to the expiration of the initial eighteen (18) months of continuation coverage.

Subsequent Qualifying Event

If a second Qualifying Event occurs during an eighteen (18) month period of COBRA Continuation of Coverage explained above, a Dependent's coverage may be continued for a maximum of thirty-six (36) months from the date of the first Qualifying Event. The second Qualifying Event must be a Qualifying Event that entitles continuation for thirty-six (36) months. In the event the Dependent loses coverage due to a Qualifying Event, and the Member then becomes entitled to Medicare, the Eligible Dependent shall have available up to thirty-six (36) months of coverage measured from the date of the Qualifying Event that causes the loss of coverage. If the Member was entitled to Medicare prior to the Qualifying Event, the Eligible Dependent shall have up to thirty-six (36) months of coverage measured from the date of entitlement to Medicare.

Electing COBRA Continuation of Coverage

The Covered Person must elect COBRA continuation coverage within sixty (60) days from the date of loss of coverage as a result of a Qualifying Event or sixty (60) days from the date The Vision Plan mails or otherwise provides the Covered Person with notification of the Covered Person's right pursuant to a Qualifying Event to elect coverage.

Notice Procedures

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or the right to an extension of COBRA coverage, as applicable).

Your notice must be mailed to:

GEHA Connection Programs Coordinator
P. O. Box 21542
Eagan, MN 55121-9930

Any notice you provide must include: (1) the name of the Plan; (2) the name and address of the Member who is or was covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address and telephone number of the person providing the notice.

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

Premiums for Continuation
The Premium payment for COBRA Continuation of Coverage shall be a monthly payment for The Vision Plan unless the qualified beneficiary chooses to pay the entire premium in advance. The rates will differ from those under the GEHA medical or dental plan in which you were enrolled. The qualified beneficiary pays Premiums by check. Payment of the initial Premium is not required until the forty-fifth (45th) day after the election.

Newborn Child or Child Placed for Adoption during Period of Continuation of Coverage
If the Member elects COBRA Continuation of Coverage and, during the period of continuation coverage, a child is born to or placed for adoption with the Member, the Member has the right to elect COBRA Continuation of Coverage for the child, provided the child satisfies the otherwise applicable Dependent Eligibility requirements and the member notifies us of the birth or placement for adoption, within thirty (30) days of the birth or placement. The period of COBRA Continuation of Coverage shall be the same as that for the Member, or as set forth below.

Open Enrollment Rights
Qualified Beneficiaries who have elected COBRA Continuation of Coverage will be given the same opportunity to change their coverage option or add or drop Dependents at open enrollment as similarly situated active employees.

Termination of COBRA Continuation of Coverage
COBRA Continuation of Coverage shall not be provided beyond whichever of the following dates is first to occur:

- The date The Vision Plan is terminated.
- The last day of the month for which the Covered Person has made the required Premium payment to continue coverage.
- The date the qualified beneficiary becomes entitled to Medicare (this applies only to Qualified Beneficiaries who become entitled to Medicare after electing COBRA continuation coverage).
- The first day of the month beginning more than thirty (30) days after the Social Security Administration determines that a qualified beneficiary, entitled to twenty-nine (29) months of coverage on account of disability, is no longer disabled.
- The date on which we terminate the qualified beneficiary's coverage for cause, for a reason other than the continuation coverage requirements of federal law.

USERRA Coverage

Rights under COBRA and USERRA are similar but not identical. Any election made pursuant to COBRA will also be an election under USERRA. COBRA and USERRA will both apply with respect to the Continuation of Coverage elected. If COBRA or USERRA provides Members and covered Dependents different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures for COBRA also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") established requirements that employers must meet for certain employees who are involved in the Uniformed Services. In addition to the rights under COBRA, employees who are involved in the Uniformed Services are entitled to rights under USERRA to continue coverage under The Vision Plan.

Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full time National Guard duty pursuant to orders issued under federal law, and the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of war or national emergency.

Service in the Uniformed Services or Service means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty, the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain duty and training by intermittent disaster response personnel of the National Disaster Medical System.

Period of Absence	Return to Work Requirement
Less than 31 days	Report to work at the beginning of the first regularly scheduled work period following the end of service plus 8 hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the employee.
More than 30 days but less than 181 days	Submit an application for employment not later than 14 days after the completion of the service, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the employee.
More than 180 days	Submit an application for employment not later than 90 days after the completion of the service.
Any period, if the absence was for purposes of an examination for fitness to perform service.	Report to work at the beginning of the first regularly scheduled work period following the end of service plus 8 hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the employee.
Any period, if you were hospitalized for or are convalescing from an Injury or Illness incurred or aggravated as a result of your service.	Apply for work or submit application as described above (depending on length of absence) when recovery is over, but recovery time is limited to two years. The 2-year period is extended by any minimum time required to accommodate circumstances beyond the employee's control that make compliance with these deadlines unreasonable or impossible.

Duration of Coverage
When a Member takes a leave for service in the Uniformed Services, USERRA coverage for the Member (and covered Dependents for whom coverage is elected) begins the day after the Member (and covered Dependents) lose coverage under The Vision Plan, and it may continue for up to 24 months. However, USERRA coverage will end earlier if one of the following events takes place: (a) A premium payment is not made within the required time; (b) Failure to return to work within the timeframe required under USERRA (see below) following the completion of service in the Uniformed Services; or (3) Rights under USERRA terminate as result of a dishonorable discharge or other conduct specified in USERRA.

Rights under USERRA will terminate if an employee fails to notify his or her employer of his or her intent to return to work within the timeframe provided under USERRA following the completion of services in the Uniformed Services by either reporting to work (when the absence was for less than 31 days) or applying for reemployment (if the absence was for more than 30 days). The time for returning to work depends on the length of the absence, as follows:

COBRA coverage and USERRA coverage begin at the same time and run concurrently. However, COBRA coverage can continue longer, depending on the qualifying event, and is subject to different early termination provisions. In contrast, USERRA coverage can continue for up to 24 months, as described earlier in this Article.

Premiums under USERRA
If a Member elects to continue coverage pursuant to USERRA, the Member will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if a Members Uniformed Service leave of absence is less than 31 days, the Member is not required to pay more than the amount paid as an active employee for the same coverage.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Purpose of this notice
GEHA understands that medical information about you and your health is personal. We are committed to protecting your health information. This notice applies to the benefits offered under GEHA's Voluntary Welfare Benefit Plan, which are GEHA's Connection Dental Plus Plan, Connection Dental Discount, and GEHA's Connection Vision Plan Powered by EyeMed (the "Vision Plan"). The notice explains your rights under HIPAA and how you can get access to your protected health information ("PHI"). It also describes how we may use and disclose your PHI, and our legal obligations concerning that information. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services, or payment for health care services.

State law
Where state law that GEHA follows is stricter and provides greater privacy protections than HIPAA, GEHA will follow the stricter applicable state law.

GEHA's designation as a HIPAA hybrid entity
GEHA as an employee organization conducts activities that are both covered and non-covered functions under HIPAA. GEHA has designated itself a hybrid entity under HIPAA, and only those sections of GEHA that perform covered functions must comply with HIPAA. The list of the designated "Health Care Components" are available here: **geha.com/HCC**

GEHA's duties
We are required by law to:

- Ensure PHI that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices regarding your PHI;
- Follow the terms of the notice that is currently in effect; and
- Notify you following a breach of your unsecured PHI as provided under law.

How we may use or disclose your PHI
We typically use or share your health information in the following ways.

***To help manage the treatment you receive*:** We can use your health information and share it with professionals who are treating you. For example, a dentist and GEHA can share your health information so we can coordinate and manage your care.

***For payment*:** We may use and disclose your PHI as we pay for your health services and manage your account. For example, we may use health information in the form of your dental history from your provider to determine whether a particular treatment is medically necessary, or to determine whether a treatment is covered. We may disclose information to assist with the subrogation of claims or to coordinate benefit payments. We may share explanation of benefits (EOBs) with the subscriber of your plan for payment purposes.

***For health care operations*:** We may use or disclose your PHI for other GEHA operations as needed. These uses and disclosures are necessary to GEHA's business operations, and can include quality assessment, customer service, legal and auditing functions, fraud and abuse detection programs, business planning and development, and general administrative activities. For example, we may use or share your PHI to develop better services for you.

***To business associates*:** We may share your PHI with our business associates that assist us in providing certain types of services and perform various activities on our behalf. For example, we may share your health information with a business associate to help detect potential fraud or abuse. Whenever an arrangement between GEHA and a business associate involves the use or sharing of your PHI, we will have a written contract that contains terms to ensure the business associate protects the privacy of your health information to the same extent as is set forth in this Notice of Privacy Practices.

***To the plan sponsor*:** We may disclose your PHI to the plan sponsor, GEHA, to permit it to perform plan administration functions. Please refer to your brochure for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI in performing plan administration functions. Additionally, summary health information may be shared for the purpose of making decisions regarding modifying, amending, or terminating the group health plan. Information may also be disclosed to the plan sponsor on whether you are participating in the group health plan.

***Organized Health Care Arrangement*:** Connection Dental Plus and The Vision Plan are both maintained by GEHA as the health plan sponsor. If you are covered by GEHA through Connection Dental Plus and The Vision Plan, the plans may share PHI with each other as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement. For example, enrollment information regarding address changes and payment information in order to coordinate benefits are some of the ways in which information may be shared.

***As required by law and for public health activities*:** We may use or disclose your PHI to the extent that federal, state, or local law requires the use or disclosure. We may also disclose your PHI for public health activities and purposes as permitted or required by law. For example, we may disclose information for the purpose of controlling disease, injury, or disability.

***To report abuse or neglect*:** We may disclose your PHI to a government authority or agency that is authorized by law to receive reports of abuse or neglect if we believe that you have been a victim of abuse, neglect or domestic violence.

***For health oversight*:** We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

***In legal proceedings and for law enforcement purposes*:** We may disclose PHI during any judicial or administrative proceeding, in response to an order of a court, or administrative tribunal, if such disclosure is expressly authorized by order. We may disclose PHI in response to a subpoena, discovery request or other lawful process, if the party seeking the information satisfactorily assures us that reasonable efforts have been made to either notify you of the request or obtain a protective order. We may, in certain situations, disclose PHI for law enforcement purposes.

***To individuals involved in your care*:** Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your PHI that directly relates to that person's involvement in your health care or payment related to your health care. You have the right to request that we do not share your PHI with these individuals. If you are not present, we may disclose your PHI based on our professional judgment of whether the disclosure would be in your best interest. In the same way, we may also disclose your PHI in the event of your incapacity or in an emergency.

***For other uses and disclosures*:** GEHA may also share your PHI for other types of activities including:

- With coroners, funeral directors, or medical examiners regarding decedents;
- To prevent or lessen a serious and imminent threat to the health or safety of a person or the public if we believe that the use or disclosure is necessary under applicable federal and state laws;
- For special government functions where certain conditions apply, for Workers' Compensation, and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the law.

Disclosures to you or your personal representative
We must give you access to your own PHI and will disclose it to you upon your request.

We will also disclose your PHI to your personal representative who has been designated as such by you and only if they have authority by law to act on your behalf in making decisions related to health care. We may require your personal representative to produce evidence of his/her authority to act on your behalf, such as a power of attorney. We may not recognize him/her if we have a reasonable belief that treating such person as your personal representative could endanger you and we decide that it is not in your best interest to treat them as your personal representative. In addition, in the event of your death, an executor, administrator, or other person authorized under the law to act on behalf of you or your estate will be treated as your personal representative.

Authorization for other uses and disclosures
Uses and disclosures other than those described in this notice will be made only with your written approval. These include:

- Uses and disclosures for marketing purposes or research;
- Uses and disclosures for the purposes of underwriting or fundraising, and
- Uses and disclosures that constitute the sale of PHI.

You may revoke an authorization at any time in writing, and we will stop using your PHI for that purpose once we receive your revocation. The revocation will not be effective for information we have already used or disclosed before you told us to stop.

Your rights
Under federal law, you have certain rights with respect to your PHI. This section explains your rights and some of our responsibilities to help you.

***Right to get a copy of health and claims records*:** You can ask to see or get access to a copy of your health and claims records and other records we have that are used to make decisions about your healthcare benefits. You can also request that we send copies of your information to a third party that you choose. We will provide a copy, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

***Right to amend*:** You can ask us to correct your health and claims records if you think they are incorrect or incomplete as long as we maintain this information. We may say no to your request, but we'll tell you why in writing within 60 days.

***Right to receive confidential communications*:** You may request we contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not. You may revoke a confidential communication request at any time in writing.

***Right to ask us to limit what we use or share ("Restriction")*:** You may ask us not to use or share certain health information for the purposes of treatment, payment, or healthcare operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction of using or disclosing the PHI for treatment, payment, or health care operations reasons, unless a law otherwise requires the disclosure. If you or your provider submits the claim to us for payment, we do not have to agree to a restriction.

***Right to get a list of those with whom we've shared information ("Accounting of Disclosures")*:** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

***Right to obtain a copy of this notice*:** You may request a paper copy of this notice, even if you have agreed to receive the notice electronically.

***Right to file a complaint*:** You can complain if you believe that we have violated your privacy rights by contacting GEHA's Privacy Officer. You may also file a complaint with the Secretary of the Department of Health and Human Services by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. No action will be taken against you for filing a complaint.

***More information about your rights*:** Please submit your requests or file any complaint or concern with our Privacy Officer at the contact information below. Forms are available at our website: **geha.com/legal/privacy-and-security**

Revisions to the Notice
We reserve the right to change the terms of our notice at any time, and the changes will apply to all information we have about you. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in Keynotes or post them on our website. We may also mail the new notice.

Contact
You may contact GEHA's Privacy Officer for further information about how to file a complaint, your rights under federal law, or this document by mail at GEHA, Attention: Privacy Officer, 310 NE Mulberry Street, Lee's Summit, MO 64086, by e-mail at privacy@geha.com, or by phone, as follows. For Connection Dental Plus or Connection Dental Discount, call (800) 793-9335, and for the Vision Plan, call (800) 821-6136.

Privacy of Health Information

Definitions

Health Care Operations means any of the following activities related to The Vision Plan:

- Conducting quality assessment and improvement activities;
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development; or
- General business management and administrative activities of The Vision Plan, including but not limited to customer service and the resolution of internal grievances.

Payment means the activities undertaken by The Vision Plan to obtain contributions or to determine or fulfill responsibility for coverage and provision of benefits under The Vision Plan, and activities undertaken by a covered health care provider or The Vision Plan to obtain or provide reimbursement for health care services. Examples include:

- Determinations of eligibility or coverage, including coordination of benefits;
- Adjudication of subrogation of claims;
- Billing, claims management, collection activities;
- Disclosures of your name, address, date of birth, social security number, payment history, account number, and the name and address of the health plan to consumer reporting agencies for purposes of collection of premium or reimbursement.

Protected Health Information ("PHI") means individually identifiable health information relating to your past, present or future physical or mental health or condition, provision of health care to you, or the past, present or future payment for health care provided to you.

Summary Health Information means information that summarizes claims history, claims expenses, or type of claims experienced by members for whom GEHA has provided health benefits under The Vision Plan and from which the names, addresses, cities, counties, dates, telephone and fax numbers, email addresses, and social security numbers and other identifying numbers have been deleted.

Disclosures to the Plan Sponsor
The Vision Plan may disclose PHI to GEHA for the following purposes:

- The Vision Plan may disclose summary health information to GEHA, for the purpose of making decisions regarding modifying, amending, or terminating The Vision Plan.
- The Vision Plan may disclose PHI to GEHA to carry out plan administration functions that GEHA performs consistent with the provisions below.

Obligations of the Plan Sponsor
The Vision Plan will disclose PHI to GEHA to carry out plan administration functions only upon receipt of a certification from GEHA that the plan documents have been amended to incorporate the following provisions.
GEHA agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan document or as required by law.
- Ensure that any agents, including subcontractor, to whom GEHA provides PHI received from The Vision Plan agree to the same restrictions and conditions that apply to GEHA with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions;
- Not use of disclose PHI in connection with any other benefit or employee benefit plan of GEHA;
- Report to The Vision Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to you in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA.
- Make available the information required to provide an accounting of disclosures;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from The Vision Plan available to the HHS Secretary for the purposes of determining The Vision Plan's compliance with HIPAA.
- If feasible, return or destroy all PHI received from The Vision Plan that GEHA still maintains in any form, and retain no copies of such PHI when no longer needed for the purposes for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to the purposes that make the return or destruction infeasible); and
- Ensure that adequate separation between The Vision Plan and GEHA is established and supported by reasonable and appropriate security measures.
- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of The Vision Plan.
- Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to The Vision Plan any security incident of which it becomes aware.

Access to and use and disclosure of PHI will be limited to only employees who have a need for the PHI in conjunction with their performance of plan administration functions for The Vision Plan, including any employee whose job functions include the following:

- Mail and Internal operations;
- Enrollment;
- Legal & Compliance;
- Customer Care Center;
- Data Analysis;
- Information Services;
- Dental Plans & Value-Added Programs;
- Accounting;
- Marketing;
- Enterprise Security & Risk Management; and
- Internal Audits.

If the persons described above do not comply with the conditions set forth in this Section, GEHA will provide a mechanism for resolving issues of noncompliance, including appropriate disciplinary sanctions.

Benefit Provisions

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.

Copay
Copay is the stated amount of Covered Expenses you must pay for insured covered services from an EyeMed participating provider.

Covered Service
A Covered Service is limited to one routine vision exam per Covered Person per Calendar Year for these plans: GEHA Health Plan High Option; or, GEHA Health Plan Standard Option; and/or GEHA Health Plan High Deductible Option; and/or GEHA Health Plan Elevate; and/or GEHA Health Plan Elevate Plus; and/or GEHA Connection Dental Federal Plan; and/or GEHA Connection Dental *Plus* Plan.
These plans also have an Eyewear Materials Benefit: GEHA Health Plan High Deductible Option.

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 as determined by EyeMed or the underwriter of the plan, Combined Insurance Company of America.

Incur/Incurred
A Covered Service is deemed Incurred on the date care, treatment or service is received.

Maximum Benefit Limits
Benefits are limited to one routine vision exam per person and/or limited eyewear materials per Calendar Year. The Maximum Benefit applies to a Covered Person even if that Covered Person's coverage has been interrupted or if that Covered Person has been covered both as a Member and as a Dependent or is covered by more than one eligible GEHA Plan. Maximum Benefit Limits apply separately to each Covered Person. See the Benefit Schedule at the end of this document for a description of how benefits are paid.

Non-participating Provider
Non-participating Provider means an Optical Provider who does not participate in the EyeMed network.

Participating Provider
Participating Provider means an Optical Provider who participates in an EyeMed network. For a list of participating locations access your GEHA web account, geha.com or call 877-808-8538.

Covered Services
Covered Services shall include only one routine eye exam per person per calendar year and limited eyewear materials for specific plans.

How to File Claims
Participating EyeMed providers will file the claim for you. Discounts are available only at in-network providers and are applied at the time of purchase. You are required to pay the discounted amounts to the provider at the time of service.

You are expected to pay the provider in full for treatment from an out-of-network provider. To obtain reimbursement from EyeMed you must file an out-of-network claim with EyeMed using a claim form obtained either by calling EyeMed at (877) 808-8538 or online at www.EyeMed.com. Itemized bills or receipts should be attached to the claim form. Send vision claims to:

EyeMed Vision Care LLC
Attn: OON Claims
P.O. Box 8054
Mason, OH 45040-7111

If you need help in filing your claim, call EyeMed toll-free at (877) 808-8538. Claims should be filed within 365 days from the date the expense for which claim is being made was incurred to include submission of all claim corrections within the 365 day claim filing period, unless timely filing was prevented by legal incapacity, provided the claim was submitted as soon as reasonably possible. EyeMed will not accept a claim submitted later than one year from the date of service, except when the member was legally incapable.

Notification of Claim Decision
You will be notified of the decision on your claim within a reasonable period of time, but no later than 30 days after receipt of your claim. If an extension of time is necessary due to matters beyond EyeMed's control, they may extend this 30-day period by up to 15 days. If this happens, EyeMed will notify you of the extension before the end of the initial 30-day period. The notice will include a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected.

If an extension is due to your failure to submit the information needed to decide the claim, the notice of extension will specifically describe the required information. You will then be given at least 45 days from your receipt of the notice to provide that information. The Vision Plan's deadline for deciding your claim shall be suspended from the date you receive the extension notice until the date the missing necessary information is provided to the Plan. If you supply the requested information, the Plan shall decide the claim within the extended period specified in the extension notice. However, if the requested information is not provided within the time specified, the claim may be decided without that information.

Claim Denial
In the event a claim is denied, in whole or in part, or if EyeMed takes another final action, the Covered Person will be advised of the following:

- The specific reason for the denial;
- Any additional material or information needed for further review of the claim, along with an explanation of why that material or information is needed;
- An explanation of the review procedure, including the time limits applicable to such review; and,
- A statement of your right to bring a civil action under ERISA, Section 502(a), if applicable.

If EyeMed relied on an internal rule, guideline, protocol or other similar criterion in denying your claim, the notice you receive will include either the specific rule, guideline, protocol or other similar criterion relied upon, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon your request.

Right of Review
If a claim is denied, in whole or in part, or if you desire to have another final action reviewed you, or an authorized representative acting on your behalf, shall have the right to request EyeMed review the benefit denial or other action. In connection with any review, you will have the opportunity to submit written comments, documents, records and other information relating to your claim. You will also have reasonable access, upon request and free of charge, to all documents, records and other information relevant to your claim. You may also obtain copies of those documents, records and other information. To request a reconsideration of a claim denial or other action, you, or an authorized representative acting on your behalf, must file a written request for reconsideration with EyeMed postmarked within one hundred and eighty (180) days after the date on which you received written notice of the denial or other final action. Failure to comply with this important deadline will cause you to forfeit any right to any further review of a denial of benefits under these procedures or in a court of law. The request must be in writing and include the member's name and ID number, the patient's name and date of birth, a phone number at which to contact you, the provider's name and address, date of service as well as the reason for the request, a copy of the initial determination and any supporting documentation. Requests for reconsideration should be sent to:

EyeMed Vision Care LLC
Attention Quality Assurance
4000 Luxottica Place
Mason, OH 45040

If you do have a claim denied, you are urged to carefully review the plan document to ensure that you follow all procedures necessary to perfect any appeal that you must make. In any instance, the plan administrators will revise these procedures as necessary to follow federal law and claim and appeal regulations under Section 503 of the Employee Retirement Income Security Act of 1974 (ERISA).

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

Within sixty (60) days after receipt of your request for reconsideration, the review will be made. Someone other than the person who processed or reviewed the original claim will review your request for reconsideration and will give no deference to the initial benefit decision. The reconsideration will take into account all information submitted by you, regardless of whether or not the information was available or presented at the initial benefit decision.

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

The EyeMed review decision will be forwarded to you in writing and will include specific reasons for the decision, references to provisions upon which the decision was based, and a statement of your right to file suit in court to obtain payment of your claim for benefits.

If EyeMed relied on an internal rule, guideline, protocol or other similar criterion in denying your request for reconsideration, the notice you receive will include either the specific rule, guideline, protocol or other similar criterion relied upon, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon your request. Similarly, if your request for reconsideration was denied on the basis of medical necessity or an experimental treatment or similar exclusion or limit, the notice will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of The Vision Plan to your circumstances, or a statement that such an explanation will be provided to you free of charge upon your request.

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

Standard of Review
The decision of EyeMed will be final and binding and will only be subject to review if such decision was arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of EyeMed shall be based only on such evidence presented to or considered by EyeMed at the time it made the decision that is now subject to review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decision that EyeMed makes, in its sole discretion, and further, constitutes agreement to the limited scope of review described in this Section.

Exhaustion of Remedies
No action at law or in equity can be brought to recover from The Vision Plan until the review procedure has been exhausted as described above

Benefit Schedule

EyeMed Plan Numbers: 9787961			
Year	**Benefits and Limitations**	**EyeMed Network Provider**	**Out-of-network Provider**
Beginning January 1, 2011	Routine Eye Exam including Dilation as necessary - Limited to one exam per covered person every 12-months.	Covered in full after $5 copay	Up to $45 Allowance
EyeMed Plan Numbers: 1023962 and 1023963			
Beginning January 1, 2020	Routine Eye Exam including Dilation as necessary - Limited to one exam per covered person every 12-months.	Covered in full	Up to $45 Allowance
EyeMed Plan Numbers: 9787979			
Beginning January 1, 2011	Routine Eye Exam including Dilation as necessary - Limited to one exam per covered person every 12-months.	Covered in full after $5 copay	Up to $45 Allowance
	Contact lens fit and follow-up; Frames; Lenses; Various Options;	Various copays and discounts	None

*Underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York.

Network Provider Discounts are available for Vision Materials purchased from EyeMed provider locations. Examples of how the plan may save you money when you purchase eyewear or other vision services a participating EyeMed provider can be found in the vision page section of the GEHA plan websites.

GOVERNMENT EMPLOYEES HEALTH ASSOCIATION, INC.
VOLUNTARY WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION SUPPLEMENT
JANUARY 1, 2019

This Summary Plan Description (SPD) is intended to comply with the minimum federal legal requirements for SPDs. To the extent any greater legal rights are afforded a Plan participant by the underlying Plan or by any state law that is not pre-empted by ERISA, those legal rights supersede the rights set forth in this SPD. *The information in this Supplement is in addition to, and/or supersedes, the information in the Certificates of Insurance and/or Benefit Summaries for the individual benefits offered under the Government Employees Health Association, Inc. Voluntary Welfare Benefit Plan (the "Plan"). Collectively, the Certificates/Summaries and this Supplement constitute the Summary Plan Description ("SPD") for the Plan.*

GENERAL INFORMATION

Plan Name: Government Employees Health Association, Inc. Voluntary Welfare Benefit Plan
(The Plan was originally effective as of January 1, 1997.)

Plan Sponsor's Name: Government Employees Health Association, Inc. ("GEHA")

Plan Sponsor's Address: 310 NE Mulberry
Lee's Summit, MO 64086-5861

Plan Sponsor's Identification Number (EIN): 44-0545275

Plan Number: 601

Plan Year End: The Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Welfare Benefit Plan Type:

Dental Benefits
Vision Benefits
Dental and Vision Discounts

Plan Administrator: GEHA
310 NE Mulberry
Lee's Summit, MO 64086-5861
(816) 257-5500

Agent for Service of Legal Process: GEHA
c/o Belinda Thompson
310 NE Mulberry
Lee's Summit, MO 64086-5861
(816) 257-5500
Service of Legal Process may also be made upon the Plan Administrator.

SOURCES OF CONTRIBUTIONS TO THE PLAN AND PLAN FUNDING MEDIUM

The Plan is funded through employee contributions. The dental and discount dental and vision benefits are funded through the Government Employees Health Association, Inc. Voluntary Welfare Benefit Fund (the "Trust"). The vision benefits are fully insured through an insurance policy purchased from an insurance company.

If a health insurance issuer ("Issuer") is responsible in whole or in part for the financing or administration of a benefit, please refer to your Insurance Card for the full name and address of the Issuer. Please refer to the applicable Certificate of Insurance to

determine whether and to what extent benefits under the Plan are guaranteed under a contract or policy of insurance issued by the Issuer, and the nature of any administrative services (e.g., claims payment) provided by the Issuer.

ELIGIBILITY FOR PARTICIPATION AND BENEFITS

The following employees and retired employees, and their dependents, of the federal government are eligible for the following Plan benefits:

Dental Benefits

- Employees or annuitants (and their eligible dependents) of the Federal Government; and
- Former federal employees or annuitants (and their eligible dependents).

Vision Benefits

- Employees or retired employees (and their eligible dependents) who are enrolled in either the High Option, the Standard, or the High Deductible Health Plan Option of the GEHA health plan under the FEHBP;
- Employees or retired employees (and their eligible dependents) who are enrolled in Elevate or Elevate Plus Option of the GEHA health plan under the FEHBP; or
- Employees or retired employees (and their eligible dependents) who are enrolled in the GEHA Connection Dental Plus Benefit under the Plan;
- Employees or retired employees (and their eligible dependents) who are enrolled in the GEHA Connection Dental Federal Plan under the Federal Employees Dental and Vision Insurance Program ("FEDVIP"); and
- Members of a special class of membership that GEHA may establish from time to time.

Dental and Vision Discounts

- Employees or retired employees (and their eligible dependents) who are not enrolled in FEDVIP.

SUMMARY OF PLAN BENEFITS

Please refer to the attached Certificates of Insurance and/or Benefit Summaries for a description of the Plan's benefits.

SPECIAL PROVISIONS

Please refer to the applicable Benefit Summary (or Certificate of Insurance) for the following information:

- ⇨ A description of discounts;
- ⇨ Any limits or exclusions on the discount benefits under the Plan;
- ⇨ Provisions governing the use of network providers;
- ⇨ The composition of the provider network; and;
- ⇨ Any conditions or limits on the selection of participating providers.

Please refer to the applicable Benefit Summary (or Certificate of Insurance) for a description of the Plan's provider network. *Provider lists are furnished automatically, without charge, as a separate document or available via a website.*

LOSS OR REDUCTION OF PLAN BENEFITS

Please refer to the applicable Certificate of Insurance and/or Benefit Summaries for a description of the circumstances that may result in disqualification, ineligibility, or the denial, loss, forfeiture, suspension, offset, or reduction of benefits.

THE PLAN SPONSOR'S RIGHT TO TERMINATE THE PLAN, OR AMEND OR ELIMINATE PLAN BENEFITS

GEHA has the right, under the terms of the Plan, to modify or amend the Plan at any time. Any modification shall be effective as of the date of the amendment, or at such later date as GEHA shall determine. GEHA also has the right to terminate the Plan at any time. Any termination of the Plan shall be effective as of the date of the termination amendment or board resolution, or such later date as GEHA shall determine.

The Certificates of Insurance and/or Benefit Summaries will disclose any Plan provisions governing the benefits, rights and obligations of participants and beneficiaries upon Plan termination or the amendment or elimination of benefits under the Plan.

To the extent applicable, the Certificates of Insurance and/or Benefit Summaries will disclose any situations where the receipt of benefits is conditioned on the imposition of a fee or charge on a participant or beneficiary, or on an individual account.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

General. Medical child support orders may create or recognize the right of a child of an eligible employee to be covered for a particular benefit provided under the Plan. Typically, such orders are issued in divorce proceedings, though they may be issued outside of divorce proceedings to address issues such as whether a child who is not financially dependent on the employee may be covered, the child's enrollment in the Plan by the parent who is not the employee, that parent's right to information, enrollment by a state agency, termination of enrollment, and the right of the custodial parent, the provider or a state agency to submit claims and receive payments.

Definitions. Unless the context indicates otherwise, the following terms shall have the following meanings:

(a) "Alternate Recipient" means any child who is recognized under a Medical Child Support Order as having a right to enrollment under the Plan.

(b) "Medical Child Support Order" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of state law which –

(i) provides for child support with respect to a child or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the Plan; or

(ii) enforces a Section 1908 State Law relating to medical child support.

(c) "Plan" means dental, vision, and discount dental and vision benefits described in the Plan, but only to the extent required by law.

(d) "Qualified Medical Child Support Order" means a Medical Child Support Order which –

(i) creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which you or your beneficiary are eligible under the Plan;

(ii) clearly specifies –

(A) your name and the last known mailing address (if any) and the name and mailing address of each Alternate Recipient covered by the Order;

(B) a reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined;

(C) the period to which the Order applies; and

(D) the plan or benefit to which the Order applies; and

(iii) does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a Section 1908 State Law relating to medical child support.

(e) "Section 1908 State Law" means a law which a state is required to have in effect under Section 1902(a)(60) of the Social Security Act. As set forth in Section 1908 of the Social Security Act, these state laws –

(i) specify when a child may be enrolled under the health coverage of the child's parent;

(ii) specify when a child's health coverage provided by a parent as required by a court or administrative order may be eliminated;

(iii) require an employer to withhold from an employee's compensation the employee's share (if any) of premiums for health coverage if the employee is required by a court or administrative order to provide health coverage for a child;

(iv) provide rights to a child's custodial parent when the child has health coverage through the insurer of the noncustodial parent; and

(v) provide rights to state agencies, including the right to garnish the wages of individuals who are required by a court or administrative order to provide health coverage to a child.

Notice. Upon the Plan's receipt of a Medical Child Support Order with respect to you, the Plan Administrator shall promptly give notice of the receipt of the Order, and give notice of these Procedures, to you and to each person specified in the Order as eligible to receive benefits under the Plan. Notice shall be given at the address specified in the Order.

Determination.

(a) The Plan Administrator shall determine whether a Medical Child Support Order is a Qualified Medical Child Support Order within a reasonable time after it is received, and shall have the right to require such evidence as may reasonably be needed to make the determination.

(b) The Plan Administrator shall notify you and the Alternate Recipient of the determination within a reasonable time after that determination is made.

(c) You or an affected Alternate Recipient may appeal a determination by the Plan Administrator that a Medical Child Support Order is or is not "qualified." Such appeal shall be made by written application to the Plan Administrator. You or the Alternate Recipient may review any documents pertinent to the appeal and may submit comments in writing to the Plan Administrator. No appeal shall be considered unless it is received by the Plan Administrator within 180 days after receipt by you or the Alternate Recipient of written notice of the determination.

(d) The Plan Administrator shall decide the appeal within 60 days after it is received. The Plan Administrator's decision on appeal shall be in writing and shall include specific reasons for the decision, expressed in a manner calculated to be understood by you and the Alternate Recipient.

Benefits Pending Determination. During any period in which the issue of whether a Medical Child Support Order is a Qualified Medical Child Support Order is being determined (by the Plan Administrator, by a court of competent jurisdiction, or otherwise), the Plan shall not be obligated to make benefit payments to or on behalf of an Alternate Recipient. The Plan shall also not be obligated to make any benefit payments to or on behalf of an Alternate Recipient during any period in which you or the Alternate Recipient has a right to appeal a prior determination regarding whether the Medical Child Support Order is a Qualified Medical Child Support Order.

Representative of Alternate Recipient. An Alternate Recipient may, by written notice to the Plan Administrator, designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

Treatment of Alternate Recipient. A person who is an Alternate Recipient under a Qualified Medical Child Support Order shall be considered a beneficiary under the Plan for the purposes of ERISA. A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a participant under the Plan for the purposes of the reporting and disclosure requirements of Part 1 of Subtitle B of Title I of ERISA.

Direct Provision of Benefits. Any payment for benefits made by the Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

CLAIMS PROCEDURES FOR GROUP HEALTH BENEFITS

The following Claims procedures will apply to the benefits provided under this Plan, but only to the extent that Claims procedures are not otherwise provided under the applicable Benefit Summary (or Certificate of Insurance).

A "Claim" is defined as any request for a Plan benefit made by a claimant, or by a representative of a claimant, that complies with the Plan's reasonable procedures for making benefit Claims. The times listed below are maximum times only. A period of time begins at the time a Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Applicable Deadlines.

- ⇨ Notification to claimant of benefit determination: 30 days from date of Claim.
- ⇨ Extension due to matters beyond the control of the Plan: 15 days from date of request (claimant must be notified prior to expiration of initial 30-day period).
- ⇨ Notification of insufficient information on the Claim: 30 days from date of Claim.
- ⇨ Response by claimant: 45 days from receipt of notice.
- ⇨ Time to file appeal from adverse benefit determination: 180 days from notice of initial adverse decision.
- ⇨ Appeal decision: 60 days from date of appeal.

Notice to Claimant of Adverse Benefit Determinations. The Plan Administrator (or its designee) will provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the determination is based.

(c) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(d) A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

(e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(f) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

(g) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or criterion; or a statement that such rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination, and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

(h) If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge upon request.

Appeals. When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information will be considered relevant to a Claim if it:

(a) Was relied upon in making the benefit determination;

(b) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(c) Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether that information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary, other than the individual who made the adverse determination or a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the named fiduciary will consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits.

- ⇨ Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- ⇨ Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- ⇨ Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage.

- ⇨ Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description Supplement and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights. If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance with Your Questions. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.