



Plan Brochure

**A VOLUNTARY DENTAL FEE-FOR-SERVICE PLAN
WITH A NATIONAL NETWORK OF PARTICIPATING DENTISTS.**

Open to *all* current and former federal employees, *all* year long.

WHO MAY ENROLL IN THIS PLAN:

All current and former federal employees and annuitants who are currently or previously eligible to enroll in the Federal Employees Health Benefits Program.

ENROLLMENT OPTIONS FOR THIS DENTAL PLAN:

Self Only
Self and One Dependent
Self and Family

These benefits are neither offered nor guaranteed under the contract with the FEHB or FEDVIP programs, but are made available to federal employees and annuitants by GEHA.

Sponsored by: Government Employees Health Association, Inc. (GEHA)

Using this Dental Brochure

Thank you for enrolling in CONNECTION Dental *Plus*. This brochure constitutes a Summary Plan Description required by ERISA Section 102. Along with any amendments, this brochure is the governing document of The Dental Plan.

CONNECTION Dental *Plus* has exclusions, limitations and waiting periods that affect the benefits you receive. You should read all pages of this dental brochure to understand your coverage.

The Table of Contents will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read Covered Services carefully. It also explains limitations on services. The Benefit Schedule will help you understand how your choice of provider affects how much you pay for services under The Dental Plan.

This dental brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the headings are self-explanatory. The Benefit Schedule is a summary of the benefits and appears on the back page of the dental brochure. Alternative Benefits and Predetermination of Benefits are explained in Benefit Provisions. Services Not Covered explains the exclusions. Read Other Dental Coverage to understand how CONNECTION Dental *Plus* works with other dental plans.

Some of the terms used in the dental brochure begin with capital letters. These terms have special meanings under The Dental Plan and many are listed in the Definitions section. When reading the provisions of this dental brochure, you can refer to this section. Becoming familiar with the defined terms will give you a better understanding of the procedures and benefits described in this dental brochure.

The Covered Services List shows services covered by CONNECTION Dental *Plus*, listed by procedure code, according to the *Current Dental Terminology*© American Dental Association guide.

Helpful Information

Contact Information:

Customer Service	(800) 793-9335
Eligibility/Benefits/Claim Status	(800) 793-9335
Participating Dentists	(800) 296-0776
Website	www.geha.com

File claims or predetermination of benefits to:

GEHA CONNECTION Dental *Plus*
Attn: Claims Department
P.O. Box 400
Independence, MO 64051-0400

Information available from the GEHA website, www.geha.com:

Review claims online – You can look up CONNECTION Dental *Plus* claim information online through a secured server. Go to Member Web Services to register. Then, you can view 18 months of claims data through your own Member Web Account, including an online version of the CONNECTION Dental *Plus* Explanation of Benefits form or EOB. The claim detail will include dates of service and dollar amounts for charges and benefits.

Locate a participating dentist – You can search online to locate a participating CONNECTION Dental provider in your area.

Obtain plan materials – Online access to the current plan materials allows you to view or print a copy of plan materials such as the CONNECTION Dental *Plus* Plan Brochure, Benefit Schedule, Covered Services List and Premium Rate Chart.

Contact our Customer Service – You can contact GEHA Customer Service by email using the secured email form on the website.

Table of Contents

Using this Dental Brochure	1	Continuation of Coverage	15
Table of Contents.....	2	USERRA Coverage	17
Definitions	2	Other Dental Coverage	19
General Information	3	Benefit Provisions.....	20
General Provisions.....	4	Covered Services	23
When Coverage Begins	5	Services Not Covered	25
When Coverage Terminates	5	Covered Services List	26
Rights of a Covered Person	7	Claim Provisions.....	28
HIPAA Notice of Privacy Practices.....	8	Benefit Schedule	32
Privacy of Health Information	13		

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.

Dental Practitioner

Any licensed dentist, dental hygienist or dentist acting within the scope of such license.

Eligible Dependent

An Eligible Dependent is:

- Your legally married spouse; and
- Each unmarried Child who is under age 25, except as provided on page 6 of this brochure.

Eligible Person

An Eligible Person is:

- Any federal employee or annuitant who is enrolled in the GEHA health plan under the Federal Employees Health Benefits Program; or
- Any federal employee or annuitant who is eligible for participation in the Federal Employees Health Benefits Program; or

- Any former federal employee or annuitant who is enrolled or enrolls in Connection Dental Plus March 1, 2009, or after.
- 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.

FEHBP

Federal Employees Health Benefits Program.

GEHA

Government Employees Health Association, Inc.

He/His

Means he or she and his or her unless the context clearly indicates otherwise.

Member

Any covered Eligible Person.

Premium

Contributions that are required to be paid to maintain coverage under The Dental Plan

We, Us and Our

Means Government Employees Health Association, Inc.

General Information

Name of the Plan

The Dental Plan shall be known as the Government Employees Health Association, Inc. Voluntary Dental Plan, also known as GEHA CONNECTION Dental *Plus*.

Type of Plan and Funding

Self-funded health and welfare plan providing dental benefits. Benefits are funded exclusively by Member premiums. Therefore, state law governing guarantee of funds may not cover benefits payable under The Dental Plan if the Plan is unable to pay benefits.

Type of Administrator

Benefits administered by GEHA

Address of Plan

GEHA CONNECTION Dental *Plus*
P.O. Box 400
Independence, MO 64051-0400
(800) 793-9335

Agent for Service of Legal Process

Larry D. McEnroe
Vice President and General Counsel
P.O. Box 400
Independence, MO 64051-0400

Plan Number 601

Plan Sponsor and its IRS Employer Identification Number:

Government Employees Health Association, Inc.
P.O. Box 400
Independence, MO 64051-0400

EIN 44-0545275

Plan Effective Date January 1, 1997

Plan Renewal Date January 1

Plan Year End December 31

Named Fiduciary and Contact Information

Larry D. McEnroe
GEHA Connection Dental *Plus*
P.O. Box 400
Independence, MO 64051-0400
(800) 793-9335

Service of legal process may also be made upon the Named Fiduciary at the Address of Plan.

Contributions

Voluntary Member contributions

The Government Employees Health Association, Inc. Voluntary Dental Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and not by state law.

We intend to maintain The Dental Plan indefinitely. However, we have the right to modify or terminate The Dental Plan at any time, and for any reason, as to any part or in its entirety, without advance notice. If The Dental Plan is amended or terminated, you will not receive benefits described in the dental 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 Dental Plan is amended, you may be entitled to receive different benefits or benefits under different conditions. However, if The Dental 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 Dental Plan.

You are entitled to this coverage if the provisions in the dental brochure have been satisfied. This dental 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 Dental Practitioner

Each Covered Person has the right to choose any licensed Dental Practitioner. If you use a Participating Provider, you will pay a lower Coinsurance than if you use a Non-participating Provider. The Dental Plan does not guarantee that Participating Providers are available in all areas or specialties.

Entire Contract; Changes

The Dental Plan and your enrollment application form the entire contract of coverage. We have the right to change the terms and conditions of The Dental Plan. Any change will be made in writing and signed by one of our officers. Any such change will be binding on all Covered Persons without notice to or consent by them. No agent may change, alter or waive any of the terms and conditions of The Dental Plan.

Grace Period

You have a thirty-one (31) day Grace Period following the due date of your Premium. If we receive your Premium during the Grace Period, your coverage will not lapse. If your Premium payment is not received within the thirty-one (31) day Grace Period, your coverage will be terminated effective the last day of the month for which your final Premium payment was made. If your coverage is terminated, any claims for treatment or services incurred during the Grace Period will not be Covered Services.

Misstatements

All statements made in an application will, in the absence of fraud, be deemed representations and not warranties. No statement made by you will be used to contest or to deny a claim unless:

- It is contained in a written statement signed and dated by you; and
- A copy of such statement has been given to you or your beneficiary, if any.

No statement, except a fraudulent misstatement, will be used to:

- Contest The Dental Plan after it has been in force for two years; or
- Deny a claim on a Covered Person who has been covered by The Dental Plan for two years.

Premium

We have the right to change our Premium rates from time to time but not more often than once every six months.

Premiums may be paid quarterly by check, money order, credit card or automatic bank draft. Monthly premium payment can be made by automatic bank draft only. If you authorize automatic bank draft, The Dental Plan shall be authorized to draw from your account the premium payment, including any increases, affected and authorized under The Dental Plan.

The amount of your premium is determined by geographical region based on the cost of dental services where you live. If you move to a different geographic region, your change to the new premium for your area will be effective on the next bank draft or billing period.

Current GEHA health plan members pay a reduced dental premium. Your premium amount will change as determined by The Dental Plan the first of the month following receipt of notice of a change in your status as an active GEHA health plan member.

The Dental Plan will not refund premium payments except for months paid in advance of the current month in which coverage terminates.

When Coverage Begins

Eligibility Date

You are eligible to request coverage on the date you are eligible for enrollment in FEHBP. You are also eligible to request coverage at any time you are eligible for FEHBP enrollment,

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 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 Dental Plan. Such an order must be qualified under federal law for The Dental 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

You must request coverage for yourself and your Eligible Dependent(s) after your Eligibility Date by:

- Completing and signing an application for coverage or completing the online enrollment form;
- Remitting your required Premium payment in full or completing a bank draft authorization form that authorizes us to draft your checking or savings account for your premium; and
- Mailing your application and Premium payment or draft authorization to us.

You may also enroll your Eligible Dependent(s) any time during your active enrollment in The Dental Plan by submitting a written request or completing the Enrollment Information Change form, which is available online at www.geha.com. If you fail to submit a written request to add your Eligible Dependent(s), they will not be enrolled in The Dental Plan. **Your payroll office will not notify The Dental Plan for you.**

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 the month next following the date we receive your application and required Premium payment.

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 and Waiting Periods as described under Covered Services.

Your Effective Date of Coverage will be subject to the required 12-month Waiting Period due to prior Voluntary Termination. All Dental Plan Waiting Periods and Benefit Percentages will begin again upon re-enrollment.

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 earliest of the following dates:

- The date The Dental Plan is terminated;
- The last day of the month in which the final Premium payment is made; or
- The last day of the month in which we receive your request for voluntary termination.

Dependents

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

- The date The Dental Plan is terminated;
- The last day of the month in which your coverage is terminated;

- The date The Dental Plan is amended so as to terminate the Dependent(s)' coverage;
- The last day of the month in which the final Premium payment is made for the Dependent(s)' coverage;
- The last day of the month in which the Dependent ceases to be an Eligible Dependent; or
- The last day of the month in which the Dependent gets married.

When Coverage Terminates *continued*

Continuation of Dependent Child Coverage After Age 25

Subject to the other terms and conditions stated herein, coverage for any unmarried Dependent Child whose coverage is terminating because he has reached age 25 may be continued if:

- The Child is incapable of self-support due to a mental incapacity or physical disability; and
- The Child's mental incapacity or physical disability started while covered and prior to age 25; and
- The Child is primarily dependent on you for support and maintenance; and
- A request for continuation and satisfactory proof of the Child's mental incapacity or physical disability is presented to us within 31 days after the Child's coverage would otherwise end; and
- Any required Premium payment is made.

We may require continued proof of the Child's mental incapacity or physical disability at reasonable intervals thereafter. Any such proof will be at your expense.

Such continued coverage will end on the earliest of:

- The last day of the month in which the Child is no longer incapable of self-support due to mental incapacity or physical disability;
- The last day of the month preceding any month in which you fail to provide any required proof or fail to make any required Premium payments; or
- The last day of the month in which your coverage terminates.

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 and Premium has been paid.

Voluntary Terminations

A Covered Person whose coverage is Voluntarily Terminated may not re-enroll until a minimum 12-month Waiting Period is satisfied. Re-enrollment

causes all Dental Plan Waiting Periods and Benefit Percentages to begin again. Voluntary Termination shall include termination of coverage because of non-payment of Premium.

To request termination of your Dental Plan coverage, call CONNECTION Dental *Plus* at (800) 793-9335 or send a written notice of termination to CONNECTION Dental *Plus*; P.O. Box 400; Independence, MO 64051-0400.

Do not assume that making changes to your Federal Employees Health Benefits Program (FEHB) or Federal Employees Dental and Vision Insurance Program (FEDVIP) coverage will automatically change your coverage with this Dental Plan. You must initiate the request for voluntary termination of your Dental Plan coverage.

The Dental Plan will not refund premiums paid for the month in which you request voluntary termination or any prior months of coverage.

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 back to the first day of the month in which the fraud was perpetrated without prejudicing any other legal right or remedy that might be available to us, and terminate the coverage.

If we terminate coverage under this provision, coverage shall be permanently terminated and the terminated person cannot re-enroll at any time in the future.

Notice of Ineligibility

You must let us know in writing within 30 days of your Dependent(s) loss of eligibility. **Your payroll office will not notify The Dental Plan for you.** Your Dependent(s)' coverage will not be continued past the time it would have ended as described in this section even if you fail to provide timely notice.

Rights of a Covered Person

As a Member in The Dental Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Members 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 Dental Plan with the U.S. Department of Labor, such as plan descriptions (filed before 1997) and annual reports;
- Obtain copies of all Dental 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 Dental Plan's annual financial report (if applicable). We are required by law to furnish each Member 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 Dental Plan to pay up to \$110 for each day's delay until the materials are received.

In addition to creating rights for Members, ERISA imposes obligations upon the persons who are responsible for the operation of The Dental Plan. These persons are referred to as "Fiduciaries" in the law. Fiduciaries must act solely in the interest of the Members 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 Dental Plan.

No one may fire you or otherwise discriminate against you to prevent you from obtaining benefits under The Dental 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 Dental 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 Dental 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 Dental Plan 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.

Your spouse or dependent may continue coverage if there is a loss of coverage under The Dental Plan as a result of a Qualifying Event. 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.

(Written in Spanish) This Summary Plan Description contains a summary in English of your plan rights and benefits under The Dental Plan. If you have difficulty understanding any part of this Summary Plan Description, contact the Plan Administrator at (800) 793-9335 for assistance.

Esta Descripción Sumaria Del Plan contiene un resumen en Inglés de sus derechos y ventajas plan El Plan Dental. Si usted tiene dificultad entendiendo cualquier parte de esta descripción Sumaria Del Plan, comuníquese con el Administrador Del Plan al (800) 793-9335 para la ayuda.

HIPAA 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 The Notice Of Privacy Practices

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is about individual privacy, and throughout this document, “you” means each individual person in your family who is insured by CONNECTION Dental *Plus*. Every member of your family should read this document carefully and understand that “you” applies to each of them as a covered individual under the plan. It describes how we may use and disclose your protected health information for purposes of payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” 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. A copy of this Notice of Privacy Practices is available at our website, www.geha.com, or by calling our Customer Service Department at (800) 793-9335 and requesting that a copy be sent to you in the mail.

Our Legal Duties Regarding Protected Health Information

We are required to follow the terms of this Notice of Privacy Practices. We understand that medical information about you and your health is personal. We are committed to protecting health information about you. We create a record of the health care claims processed for administration purposes, and this notice applies to all of the records we maintain. Your personal doctor, health care provider or hospital may have different policies or notices regarding their use and disclosure of your protected health information created at their location.

We are required by law to:

- Ensure protected health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices regarding your protected health information; and
- Follow the terms of the notice that is currently in effect.

Revision Of The Notice Of Privacy Practices

We reserve the right to change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time, including information created or received prior to the effective date of the notice revision.

We are required to promptly revise and distribute a revised Notice of Privacy Practices to you whenever there is a material change to the uses or disclosures, your individual rights, our legal duties or other privacy practices stated in the notice. Except when required by law, a material change to any term of this notice will be implemented upon the effective date of the notice in which the material change is reflected. When the Notice of Privacy Practices has been revised, the revision will also be available at our website, www.geha.com, or by calling our Customer Service Department at (800) 793-9335 and requesting that a revised copy be sent to you in the mail.

How We May Use Or Disclose Your Protected Health Information

The following describes different ways we may use and disclose your health information without your authorization. For each use or disclosure, an explanation follows to explain what we mean and present some examples. Not every use or disclosure will be listed.

Organized Health Care Arrangement:

CONNECTION Dental *Plus* is maintained by GEHA as the health plan sponsor. If you are covered by GEHA through the Federal Health Benefits Program, GEHA and CONNECTION Dental *Plus* may share information. 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.

HIPAA Notice of Privacy Practices *continued*

If you are *not* a member of GEHA through the Federal Health Benefits Program, *no* information about you will be shared with the federal health benefits administration of GEHA.

Payment: We may use and disclose protected health information about you to determine and provide eligibility for benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility, to coordinate coverage or to obtain premiums. 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 another entity to assist with the subrogation of claims or to another plan to coordinate benefit payments.

Health Care Operations: We may use or disclose your protected health information for other CONNECTION Dental *Plus* operations as necessary to administer CONNECTION Dental *Plus*, including quality assessment, customer service, legal and auditing functions, business planning and development, and general administrative activities. We may share your protected health information as necessary with third party “business associates” that assist us in performing these activities. For example, we may share your health information with a third party to help detect potential fraud or abuse. Whenever an arrangement between CONNECTION Dental *Plus* and a business associate involves the use or disclosure of your protected health information, we will have a written contract with the business associate that contains terms to ensure that the business associate protects the privacy of your health information to the same extent as is set forth in this Notice of Privacy Practices.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address will be used to send you a newsletter about the services we offer, health resources, and other information related to your health.

To Plan Sponsors: We may disclose your protected health information to the plan sponsor 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 protected health information 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.

Personal Representatives: A person is your personal representative only if they have authority by law to act on your behalf in making decisions related to health care. They then must be given the same consideration as you and we may disclose your protected health information to them. We may require your personal representative to produce evidence of his/her authority to act on your behalf. 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 him/her 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.

You may also be a personal representative by law for another individual in your family, such as a minor child or an incapacitated adult. Minor children may have some rights as specified in state consent laws that relate directly to minors.

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 protected health information that directly relates to that person’s involvement in your health care or payment related to your health care. If you are not present, we may disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. In the same way, we may also disclose your medical information in the event of your incapacity or in an emergency. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person who is responsible for your care, of your location, general condition or death. We may also use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

HIPAA Notice of Privacy Practices *continued*

Other Permitted Or Required Uses And Disclosures That May Be Made Without Your Consent, Authorization Or Opportunity To Object

We may also use and disclose your protected health information in the following situations without your authorization. These situations include the following:

Required By Law: We may use or disclose your protected health information to the extent that federal, state or local law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes as follows:

- To a public health authority that is permitted by law to collect or receive the information for the purpose of controlling disease, injury or disability, including, but not limited to, reporting of vital statistics, the conduct of public health surveillance, public health investigations and public health interventions, and, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority;
- To a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect; or
- If authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information to a governmental authority or agency authorized to receive such information, if we believe that you have been a victim of abuse, neglect or domestic violence. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Health Oversight: We may disclose protected health information 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.

Legal Proceedings: We may disclose protected health information 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 protected health information 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.

Law Enforcement: We may disclose protected health information for law enforcement purposes. These law enforcement purposes include:

- Legal orders, warrants, subpoenas or summons;
- Information for identifying and locating a suspect, fugitive, material witness or missing person;
- Circumstances pertaining to victims of a crime;
- Suspicion that death occurred as a result of criminal conduct; or
- Crime occurring on a GEHA premise.

Decedents: Protected health information may be disclosed to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

Threats to Health or Safety: Under applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel as follows:

- For activities deemed necessary by appropriate military command authorities; or
- To foreign military authorities if you are a member of that foreign military service.

We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

HIPAA Notice of Privacy Practices *continued*

Workers' Compensation: We may disclose health information to comply with laws relating to worker's compensation or other similar programs established by law.

Inmates or Those in Lawful Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, your protected health information may be disclosed to the correctional institution or to the law enforcement official for:

- The provision of health care to you;
- The health and safety of you, other inmates and officers and employees of the correctional institution;
- The health and safety of any person responsible for transporting inmates or transferring inmates between facilities; or
- The enforcement of law on the premises of the correctional institution, and the administration and maintenance of safety, security and order of the correctional institution.

Required Uses and Disclosures: Under the law, we must make disclosures to you or your personal representative upon request. We also must make disclosures 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.

Authorization For Other Uses And Disclosures

Uses and disclosures other than those in this notice will be made only with your written authorization. You may revoke an authorization at any time in writing. If you revoke an authorization, it will not affect any action taken or any information released by us prior to receiving and processing your request to revoke the authorization. Please make these requests in writing to our Privacy Officer. Forms are available on our website at www.geha.com or may be requested through our Customer Service Department at (800) 793-9335.

Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Right to Request Restrictions: You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be

disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. CONNECTION Dental *Plus* is not required to agree to a restriction that you may request. If CONNECTION Dental *Plus* does agree to the requested restriction, we will advise you in writing, and from that time forward we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment to you or as defined by law. You may revoke a restriction at any time in writing. If you revoke a restriction, it will not affect any action taken toward an individual you previously restricted or any information we refused to release prior to receiving and processing your request to revoke the restriction. We may also terminate our agreement to a restriction and would contact you if this situation should occur. Please make these requests in writing to our Privacy Officer. Forms are available on our website at www.geha.com or may be requested through our Customer Service Department at (800) 793-9335.

Right to Receive Confidential Communications:

We will accommodate written reasonable requests to receive communication of protected health information by alternative means or at alternative locations if you provide a clear statement that the disclosure of all or part of that information could endanger you. We will ask you to provide an alternative method of contact or address. We will advise you in writing, and from that time forward, we will contact you by alternative means or location as agreed to in our response. You may revoke a confidential communication at any time in writing. If you revoke a confidential communication, it will not affect any action taken toward an individual you previously restricted or any information we refused to release prior to receiving and processing your request to revoke the confidential communication. Please make these requests in writing to our Privacy Officer. Forms are available on our website at www.geha.com or may be requested through our Customer Service Department at (800) 793-9335.

Right of Access to Inspect and Copy: You may have access upon written request to inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A fee may be charged for copying, postage, and for preparing an explanation or summary of your protected health information upon your request. A

HIPAA Notice of Privacy Practices *continued*

“designated record set” contains dental and payment records and any other records that CONNECTION Dental *Plus* uses for making decisions about you. You may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. In most cases, we will provide the requested information within 30 days if the information is maintained onsite or within 60 days if the information is maintained offsite. When a decision to deny access has been made, you may have a right to have this decision reviewed in some circumstances. Please make this request in writing to our Privacy Officer. Forms are available on our website at www.geha.com or may be requested through our Customer Service Department at (800) 793-9335.

Right to Amend: You may request in writing an amendment of protected health information about yourself in a designated record set for as long as we maintain this information. A request for amendment may be denied if it is determined that the protected health information or record that is the subject of the request meets any of the following criteria:

- Was not created by CONNECTION Dental *Plus*;
- Is not part of the designated record set;
- Would not be available for inspection under access guidelines; or
- Is accurate and complete.

In most cases, we will act upon your request within 60 days. If we deny your request to amend, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please make this request in writing to our Privacy Officer. Forms are available on our website at www.geha.com or may be requested through our Customer Service Department at (800) 793-9335.

Right to Receive an Accounting of Disclosures:

You may request in writing to obtain an accounting of disclosures. This right applies to disclosures we (or our business associates) have made for purposes not related to payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, to a personal representative or any disclosures you have specifically authorized. You have the right to receive an accounting of disclosures that occur after April 14, 2003, and for a specified period of time up to six years. You may request a shorter specific timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request an accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to additional requests. Please make this request in writing to our Privacy Officer. Forms are available on our website at geha.com or may be requested through our Customer Service Department at (800) 793-9335.

Right to Obtain a Copy of this Notice: You may obtain a paper copy of this notice upon request or view and print a copy electronically at www.geha.com.

Complaints

If you believe these privacy rights have been violated, you may file a written complaint with GEHA’s Privacy Officer or the Secretary of the Department of Health and Human Services. No retaliation will occur against you for filing a complaint.

Contact

You may contact GEHA’s Privacy Officer for further information about the complaint process or for further explanation of this document by mail at GEHA, Attention: Privacy Officer, P.O. Box 438, Independence, MO, 64051-0438, or by phone at (800) 793-9335.

Privacy of Health Information

Definitions

Health Care Operations means any of the following activities related to The Dental 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 Dental Plan, including but not limited to customer service and the resolution of internal grievances.

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

- Determinations of eligibility or coverage, including coordination of benefits;
- Adjudication or subrogation of claims;
- Billing, claims management, collection activities;
- Review of health care services with respect to medical necessity or justification of charges;
- Utilization review activities, including predetermination of benefits; and
- 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 Dental 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 Dental Plan may disclose PHI to GEHA for the following purposes:

- The Dental Plan may disclose summary health information to GEHA, for the purpose of making decisions regarding modifying, amending, or terminating The Dental Plan.
- The Dental Plan may disclose to GEHA information on whether you are participating in The Dental Plan, or have enrolled in or disenrolled from The Dental Plan.
- The Dental 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 Dental 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 a subcontractor, to whom GEHA provides PHI received from The Dental Plan agree to the same restrictions and conditions that apply to GEHA with respect to such PHI;

Privacy of Health Information *continued*

- Not use or disclose PHI for employment-related actions and decisions;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of GEHA;
- Report to The Dental 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 Dental Plan available to the HHS Secretary for the purposes of determining The Dental Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from The Dental Plan that GEHA still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Ensure that adequate separation between The Dental 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 Dental 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 Dental 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 Dental Plan, including any employee whose job functions include the following:

- Mail and computer operations;
- Enrollment;
- Claims;
- Customer Service;
- Quality Assurance;
- Cost Recovery;
- Legal;
- Data Analysis;
- Network Services;
- PPOs;
- Connection Dental;
- Provider Records;
- Accounting;
- Communication Services;
- Appeals and Grievances;
- Internal Audits; and
- Managed Care.

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.

Continuation of Coverage

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

COBRA Continuation of Coverage is a continuation of The Dental 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”. Your Eligible Dependents could become qualified beneficiaries if coverage under The Dental 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 accumulation of Deductibles or benefits paid prior to the qualifying event which had been credited toward any Deductible or Maximum Benefit Limits of The Dental Plan will be retained.

Also, no new or additional Waiting Periods will apply.

Qualifying Events

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

- A Member’s death;
- Divorce or legal separation from a Member. If your spouse reduces or eliminates coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce and legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation;
- A Dependent Child ceasing to qualify as a Dependent Child.

You Must Give Notice of Qualifying Events

The Dental 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 Dental Plan of any qualifying event and to provide The Dental Plan with all information needed to meet its obligation to provide continuing coverage. Your employer or payroll office will not notify The Dental Plan when a Qualifying Event occurs.** You must provide this notice to the Plan Administrator within 60 days after the qualifying event occurs by sending written notice to:

CONNECTION Dental *Plus* Administrator
P. O. Box 400
Independence, MO 64051-0400

In order to protect your family’s rights, you should keep The Dental Plan informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

How COBRA Coverage is Provided

Once the Plan Administrator receives notice 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.

Period of Continuation Coverage for Covered Eligible Dependents

If a Covered Eligible Dependent elects COBRA Continuation of Coverage, coverage may be continued for up to thirty-six (36) months measured from the date of the Qualifying Event.

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 Laws) within sixty (60) days after the date of the Qualifying Event. **The disability extension is available only if the individual notifies The Dental Plan in writing of the Social Security Administrator’s determination of disability within 60 days after the latest of: (1) the date of the Social Security Administration’s disability determination;**

Continuation of Coverage *continued*

Notice Procedures

Warning: If your notice is late or if you do not follow these notice procedures, 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 Dental *Plus*
P.O. Box 400
Independence, MO 64051-0400**

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 amount for COBRA Continuation of Coverage shall be the same as the current Premium payments for The Dental Plan, except as required by law.

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 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 Dental Plan is terminated.
- The last day of the month for which the Covered Person fails to make the required Premium payment to continue coverage.
- The date the Qualified Beneficiary becomes entitled to Medicare (this applies only to the Qualified Beneficiary who becomes eligible for 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 Dental 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.

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 Dental 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 employer of his 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 absence was for less than 31 days) or applying for reemployment (if 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.

USERRA Coverage *continued*

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.

Other Dental Coverage

Coordination of Benefits

CONNECTION Dental *Plus* supplements other dental coverage you may have so it pays after other dental benefits. If you have other coverage, your other carrier's explanation of benefits is necessary before CONNECTION Dental *Plus* benefits can be paid. If a Covered Person is also covered under Other Dental Coverage, we pay the lesser of our benefits in full or a reduced amount that when added to the benefits payable by the other coverage will not exceed 100% of the Covered Expenses.

Definition

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

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

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

Right to Receive and Release Needed Information

We have the right to obtain or give information needed to determine benefits available from Other Dental Coverage. This can be from or to any other insurance company, organization or person, without notice to or consent of the Covered Person.

Any Covered Person claiming benefits must furnish us with the necessary information needed to determine Other Dental Coverage benefit payments. Failure to provide such information will be cause for termination. Such termination will be considered Voluntary Termination.

Right of Recovery

We have the right to retrieve any overpayments that may have been paid over that called for by these or any other provisions. This can be from the Covered Person for whom the payments were made. It can also be from any other insurance company or organization. Covered Persons shall fully cooperate with us in obtaining reimbursement of overpaid amounts.

Benefit Provisions

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.

Alternative Benefit

In some cases, you have a choice of treatment options. Dental Treatment and Services are limited 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 Alternative Benefit. Any difference between the Alternative Benefit and the charge actually incurred is your responsibility, including any applicable coinsurance.

We decide Alternative Benefit for Covered Services when the claim is received. To avoid incurring expenses we will not cover, we encourage you to request a Predetermination of Benefits before treatment is started.

American Dental Association (ADA)

The American Dental Association (ADA) Users Manual, *Current Dental Terminology*, shall be the reference for the selected procedure codes and description of Covered Services listed in the Covered Services List.

Benefit Percentage

Subject to all Dental Plan provisions, the Benefit Percentage is the benefit amount payable by us for Covered Services after Waiting Periods and Deductibles have been satisfied, and after considering any dental benefits payable by any Other Dental Coverage. Benefit percentages are different for Participating and Non-participating Providers.

Benefit Schedule

Benefit Schedule is the chart that lists the Benefit Percentages, Deductibles, Maximum Benefit Limits and Waiting Periods applicable to each Class of Covered Services.

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.

Coinsurance

Coinsurance is the stated percentage of Covered Expenses you must pay after you have met any applicable Deductible. When you use a Participating Provider, we pay a percentage of a Covered Expense and you are responsible for the remaining percentage; i.e. the Coinsurance. Remember, if you use Participating Providers, your share of Covered Expenses (after meeting any Deductible) is limited to the difference between the Covered Expense and our payment. A Participating Provider cannot balance bill you for any amount that exceeds the Maximum Allowable Charge for Covered Services.

If you use a Non-participating Provider, you will be responsible for any excess charge over our Covered Expense allowance. Example: the Non-participating Provider charges you \$100 for a Class C Covered Service, but our Covered Expense allowance is \$95. If we pay 50% of the \$95, then you are responsible for the 50% Coinsurance, plus the difference between the actual charge and our allowance. In this example, your responsibility would be \$47.50 (50% of \$95) plus the \$5 excess charge for a total of \$52.50.

If a provider waives (does not require you to pay) the Coinsurance for services provided, we are not obligated to pay the full percentage of the amount of the provider's original charge we would otherwise have paid. A provider or supplier who waives Coinsurance or Deductibles is misstating the actual charge. This practice may be in violation of the law. We will base our percentage on the fee actually charged or the Maximum Allowable Charge, whichever is less.

Benefit Provisions *continued*

Cosmetic Procedure

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

Covered Expense

Covered Expense means the lesser of the charges actually incurred or the Maximum Allowable Charge where care was received.

Covered Service

A Covered Service is a service listed in the Covered Services List. 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. Services not listed in the Covered Services List are not Covered Services.

Deductible

The deductible is the initial amount of Class B and/or Class C Covered Services incurred in any Calendar Year for which no benefits are payable. It applies separately to each Covered Person each Calendar Year.

Deductibles are shown in the Benefit Schedule and apply separately to Class B and Class C services. Each Calendar Year, we will deduct this amount from the amount of Class B and Class C Covered Services incurred during that year before we determine the benefits payable for any remaining Class B and Class C Covered Services. Deductibles are your responsibility.

Incur/Incurred

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

Maximum Benefit Limits

A single Calendar Year and lifetime 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. Maximum Benefit Limits apply separately to each Covered Person. See Benefit Schedule.

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.

Non-participating Provider

Non-participating Provider means a Dental Practitioner who does not participate in the CONNECTION Dental network. Non-participating Providers are not required to limit charges to the Maximum Allowable Charge and can balance bill you for the difference between the Maximum Allowable Charge and their charges. If you use a Non-participating Provider, you will be required to pay a higher Coinsurance than if you use a Participating Provider.

Participating Provider

Participating Provider means a Dental Practitioner who participates in the CONNECTION Dental network and agrees to limit charges to a Maximum Charge as determined by the CONNECTION Dental network. If you use a Participating Provider, you will pay a lower Coinsurance than if you used a Non-participating Provider.

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 can be obtained from Non-participating Providers.

Information on participating dentists can be obtained free of charge. Visit our website at www.geha.com or call (800) 296-0776.

Benefit Provisions *continued*

Predetermination of Benefits

The Dental Plan does not require predetermination of benefits. However, we will respond to a request to preauthorize services with an estimate of covered services. The estimate 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 preauthorize any extensive treatment. By preauthorizing 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 preauthorize 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.

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 The Dental Plan and the date dental services are covered.

Waiting Period for re-enrollment after Voluntary Termination means the period of time between the date coverage is Voluntarily Terminated and the date the Member is eligible to re-enroll in The Dental Plan.

Covered Services

Covered Services shall include only those services specifically listed in the Covered Services List. Covered Services are subject to Alternative Benefit, Coinsurance, Deductibles, Maximum Benefit Limits, Waiting Periods and the other limitations described herein. We will consider any benefits payable by any Other Dental Coverage you have before we calculate benefits payable by us.

Class A, Class B and Class C Covered Services have a combined Calendar Year Maximum Benefit per Covered Person of \$1,200.

Class A

Class A Covered Services do not have a Waiting Period or Deductible. We will pay different Benefit Percentages for Participating Providers and Non-participating Providers. See the Benefit Schedule on the back page of this brochure for correct Benefit Percentages.

Class A Covered Services shall be limited as follows:

- Oral evaluations (all types) and Prophylaxis – a maximum of two times per Calendar Year.
- Bitewing X-rays – a maximum of one time per Calendar Year.
- Topical fluoride application – limited to Covered Persons under 18 years of age, a maximum of once per Calendar Year.

Class B

Class B Covered Services do not have a Waiting Period. There is a \$50 Calendar Year Deductible per Covered Person. We will pay different Benefit Percentages for Participating Providers and Non-participating Providers. See Benefit Schedule on the back page of this brochure for correct Benefit Percentages.

Class B Covered Services shall be limited as follows:

- Full mouth X-rays/panoramic X-rays – a maximum of once every four Calendar Years.
- Sealants – for Covered Persons under 18 years of age on the occlusal (biting) surfaces of unrestored permanent teeth only. A maximum of one per tooth per lifetime.
- Space maintainers – for prematurely lost teeth of Covered Persons 12 years of age and under, initial appliance(s) only.

- Fillings – limited to one restoration per tooth surface every two Calendar Years. Subject to least costly, dentally accepted material.
- Prefabricated stainless steel crowns – for Covered Persons under 18 years of age on primary teeth only. One per tooth every three Calendar Years.
- Prefabricated esthetic coated stainless steel crowns – for Covered Persons under age 18 years of age on anterior primary teeth only. One per tooth every three Calendar Years.
- Adjustment to denture and partial denture – two per Calendar Year, at least 6 months after delivery of appliance.

Class C

Class C Covered Services have a 12-month Waiting Period and a \$100 Calendar Year Deductible per Covered Person. We will pay different Benefit Percentages for Participating Providers and Non-participating Providers. See Benefit Schedule on the back page of this brochure for correct Benefit Percentages.

Class C Covered Services shall be limited as follows:

- Inlays and onlays – when required for restorative purposes. Subject to least costly, dentally accepted material.
 - Replacement inlays and onlays are limited to one per tooth, five years after initial or prior placement unless required as a result of an Accidental Bodily Injury.
- Crowns – when required for restorative purposes. Subject to least costly, dentally accepted material.
 - Replacement crowns are limited to one per tooth, five years after initial or prior placement unless required as a result of an Accidental Bodily Injury.
- Recent inlays, onlays, crowns, cast or prefabricated post and core – one per tooth per Calendar Year, at least 6 months after initial placement.
- Therapeutic pulpotomy – for Covered Persons under 18 years of age.
- Clinical crown lengthening – hard tissue – one per tooth per lifetime.
- Retreatment of root canal – at least 12 months after prior root canal therapy.
- Periodontal scaling and root planing – limited to once per quadrant every two Calendar Years.

Covered Services *continued*

- Periodontal Maintenance – limited to two times per Calendar Year.
- 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 Effective Date of Coverage.
- The replacement of an existing prosthodontic device will be considered a Covered Service only if at least one of the following conditions is met:
 - The replacement appliance is required because at least one natural tooth was necessarily extracted after the date the person became a Covered Person and the existing appliance could not have been made serviceable. If the existing appliance could have been made serviceable, benefits will be payable only for the expense for that portion of the replacement appliance that replaces the natural teeth extracted after the date the person became a Covered Person.
 - The replacement appliance replaces an existing appliance that is at least five years old and cannot be made serviceable.
 - The replacement appliance is required as the result of Accidental Bodily Injury that occurs after the date the person became a Covered Person.
- Denture rebase, relines, or tissue conditioning – a maximum of once in any 12 consecutive month period and only 12 months after initial insertion.
- Recent fixed partial denture – limited to one per Calendar Year, after 12 months have passed since initial placement.
- Replacement of all teeth and acrylic on cast metal frame – limited to once every five years.
- General Anesthesia – limited to complex covered oral surgery.

Class D

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

Class D Covered Services have a 24-month Waiting Period per Covered Child. There is no Deductible. We will pay up to \$50 per month toward covered treatment by Participating Providers or up to \$25 a month toward covered treatment by Non-participating Providers.

Orthodontic care includes the coordinated diagnosis and treatment of a full-banded case.

The limitations on Class D Covered Services shall be:

- Maximum Benefit payable each Calendar Year per Covered Child is \$600 toward covered treatment by a Participating Provider or \$300 toward covered treatment by a Non-participating Provider.
- Lifetime Maximum benefit per Covered Child is \$1,200 toward covered treatment by a Participating Provider or \$600 toward covered treatment by a Non-participating Provider.
- Covered Services are limited to an active treatment phase that begins when the bands are first placed on the teeth and ends after 24 consecutive months or when the bands are removed from the teeth, whichever comes first.
- Initial placement of the bands on the teeth must be incurred after the Dependent Child is a Covered Child.
- Covered Services are limited to the portion of active treatment incurred while the Dependent Child is a Covered Child.
- The active treatment phase must be at least 6 consecutive months in length.
- Benefits for active treatment will end 24 months from initial placement of bands or when bands are removed from the teeth, whichever comes first.

Orthodontia services not covered:

- Limited orthodontic treatment
- Interceptive orthodontic treatment
- Minor orthodontic treatment for tooth guidance
- To control harmful habit

Services Not Covered

Benefits will not be payable for any services not specifically listed in the Covered Service List. In addition, benefits will not be payable for any expense incurred for or in connection with:

1. 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.
2. Missed or canceled appointments, telephone consultations, completion of claim form required by us or forwarding records requested by us.
3. Dentures that have been lost, stolen or misplaced.
4. Duplicate dentures, appliances, devices or X-rays.
5. Services or treatment not generally recognized by the dental profession as necessary for treatment of the condition that are experimental, or for which there is no reasonable expectation of effective treatment.
6. Services or treatment provided for oral hygiene instruction or dietary counseling for the control of dental caries and plaque.
7. 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.
8. Services or treatment covered by any Workers' Compensation Law or Act or similar legislation.
9. Congenital malformations.
10. Repair or replacement of orthodontic appliance.
11. Services or treatment provided primarily for Cosmetic Procedures.
12. Services or treatment provided by a member of your immediate family or a member of the immediate family of your spouse.
13. Any treatment not prescribed or performed by a licensed physician or Dental Practitioner.
14. Services or treatment for which no charge would be made in absence of this coverage.
15. War or act of war, whether declared or undeclared, or from police or military service for any country or organization.
16. Services or treatment provided as a result of intentionally self-inflicted injury or illness.
17. 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.
18. Office infection control.
19. Implant placement or removal, appliances placed on, or services associated with implants.
20. 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.
21. Services or treatment started or performed before the Effective Date of Coverage.
22. 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.
23. General anesthesia provided in connection with services that are not covered.
24. Precision dentures or characterization or personalization of crowns, dentures or fillings.
25. Services or treatment that are necessary due to patient failure to follow the Dental Practitioner's instructions.
26. Services or treatment that are not the least costly alternative treatment that accomplishes a result that meets accepted standards of professional dental care as determined by us.
27. Any services or treatment that are part of the complete dental procedure are considered components of, and included in, the fee for the complete procedure.
28. Services rendered after the termination of coverage, except under elected Continuation of Coverage.
29. Services paid for by the Federal Employee Health Benefit Plan.
30. Service or care required as a result of complications from a treatment or service not covered under The Dental Plan.
31. Fraudulent claims for service.
32. 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.

Covered Services List

Covered Services shall include only those services listed specifically below. Covered Services are subject to Alternative Benefit, Coinsurance, Deductibles, Maximum Benefit Limits, Predetermination of Benefits, Waiting Periods, and the other limitations and exclusions described in the CONNECTION Dental *Plus* plan brochure. The Dental Plan reserves the right to add, change or delete procedures as required by changes in Current Dental Terminology by the ADA.

Current Dental Terminology © American Dental Association

Class A - No deductible, No Waiting Period

Diagnostic

D0120 Periodic Oral Evaluation
D0140 Limited Oral Evaluation-Problem Focused
D0145 Oral Evaluation Under age 3
D0150 Comprehensive Oral Evaluation
D0180 Comprehensive Periodontal Evaluation
D0270 Bitewing-Single Film
D0272 Bitewings-Two Films
D0273 Bitewings-Three Films
D0274 Bitewings-Four Films
D0277 Vertical Bitewings-Seven To Eight Films

Preventive

D1110 Prophylaxis Adults
D1120 Prophylaxis Child
D1203 Topical Application Of Fluoride (Prophy Not Incl.) Child

Class B - \$50 Calendar Year Deductible

Per Person, No Waiting Period

Diagnostic

D0210 Intraoral-Complete Series (Including Bitewings)
D0220 Intraoral-Periapical - First Film
D0230 Intraoral-Periapical - Each Add Film
D0330 Panoramic Film
D0460 Pulp Vitality Tests

Preventive

D1351 Sealant-Per Tooth
D1510 Space Maintainer-Fixed Unilateral
D1515 Space Maintainer-Fixed Bilateral
D1520 Space Maintainer-Removable Unilateral
D1525 Space Maintainer-Removable Bilateral

Restorative

D2140 Amalgam-1 Surface
D2150 Amalgam-2 Surfaces
D2160 Amalgam-3 Surfaces
D2161 Amalgam-4 Or More Surfaces
D2330 Resin-1 Surface, Anterior
D2331 Resin-2 Surfaces, Anterior
D2332 Resin-3 Surfaces, Anterior
D2335 Resin-4 Or More Surf or Inv Incisal Angle, Ant.
*D2391 Resin-Based Composite 1 Surface, Posterior
*D2392 Resin-Based Composite 2 Surfaces, Posterior
*D2393 Resin-Based Composite 3 Surfaces, Posterior
*D2394 Resin-Based Composite 4 Or More Surf, Posterior
D2930 Prefab Stainless Steel Crown - Primary Tooth
D2934 Prefab Esthetic Coated Stainless Steel Crown - Primary Tooth
D2951 Pin Retention-Per Tooth, In Add To Restoration

Prosthodontics - Removable

D5410 Adjust Complete Denture-Upper
D5411 Adjust Complete Denture-Lower
D5421 Adjust Partial Denture-Upper
D5422 Adjust Partial Denture- Lower

Oral Surgery

D7111 Extraction-Coronal Remnants Deciduous Tooth
D7140 Extraction-Erupted Tooth Or Exposed Root
D7210 Surgical Rem Of Erupted Tooth
D7250 Surgical Rem Of Residual T Roots-Cutting Proc

D7310 Alveoloplasty In Conj W/ Extract-Per Quad
D7311 Alveoloplasty In Conj W/Extract-1 to 3 T Per Quad
D7320 Alveoloplasty Not In Conj W/ Extract-Per Quad
D7321 Alveoloplasty Not in Conj W/Extract-1 to 3 T Per Quad
D7450 Rem. Benign Odontogenic Cyst Or Tumor-To 1.25cm
D7510 Incision & Drainage Abscess-Intraoral Soft Tissue
D7511 Incision & Drainage Abscess-Intraoral Soft Tissue Complicated

D7960 Frenulectomy-Separate Procedure
D7963 Frenuloplasty
D7970 Excision Of Hyperplastic Tissue-Per Arch
D7971 Excision Of Pericoronal Gingiva

Miscellaneous

D9110 Palliative (Emergency) Treatment-Minor Proc.
D9910 Application Of Desensitizing Medicament

Class C - \$100 Calendar Year Deductible Per Person, 12-Month Waiting Period

Restorative

D2390 Resin-Based Composite Crown, Anterior
D2520 Inlay-Metallic-2 Surfaces
D2530 Inlay-Metallic-3 Or More Surfaces
D2542 Onlay-Metallic-2 Surfaces
D2543 Onlay-Metallic-3 Surfaces
D2544 Onlay-Metallic-4 Or More Surfaces
*D2710 Crown-Resin (Laboratory)
*D2712 Crown-¾ Resin-Based Composite (Indirect)
*D2720 Crown-Resin With High Noble Metal
*D2721 Crown-Resin With Predominantly Base Metal
*D2722 Crown-Resin With Noble Metal
*D2740 Crown-Porcelain/Ceramic Substrate
*D2750 Crown-Porcelain Fused To High Noble Metal
D2751 Crown-Porcelain Fused To Predom Base Metal
*D2752 Crown-Porcelain Fused To Noble Metal
D2781 Crown ¾ Cast Predominately Base Metal
*D2790 Crown-Full Cast High Noble Metal
D2791 Crown-Full Cast Predom Base Metal
*D2792 Crown-Full Cast Noble Metal
D2910 Recement Inlay
D2915 Recement Cast or Prefabricated Post and Core
D2920 Recement Crown
D2940 Sedative Fillings
D2950 Core Buildup, Including Any Pins
*D2952 Cast Post & Core In Addition To Crown
*D2953 Each Additional Cast Post-Same Tooth
D2954 Prefabricated Post & Core In Addition To Crown
*D2957 Each Additional Prefabricated Post-Same Tooth

Endodontics

D3110 Pulp Cap-Direct (Excluding Final Restoration)
D3220 Therapeutic Pulpotomy (Exc Final Restoration)
D3221 Gross Pulpal Debrid, Primary & Perm Teeth
D3222 Partial pulpotomy for apexogenesis
D3310 Root Canal Therapy-Ant. (Exc Final Rest)
D3320 Root Canal Therapy-Bicuspid (Exc Final Rest)
D3330 Root Canal Therapy-Molar (Exc Final Rest)
D3346 Retreat of Prev Root Canal Therapy-Anterior
D3347 Retreat Of Prev. Root Canal Therapy-Bicus.
D3348 Retreat Of Prev Root Canal Therapy-Molar

Covered Services List *continued*

Class C *continued*

Endodontics *continued*

- D3410 Apicoectomy/Periradicular Surgery-Anterior
- D3421 Apicoectomy/Periradicular Surgery-Bicuspid
- D3425 Apicoectomy/Periradicular Surgery-Molar
- D3426 Apicoectomy/Periradicular Surgery (Add'l Root)
- D3430 Retrograde Filling-Per Root

Periodontics

- D4210 Gingivectomy/Gingivoplasty-4 Or More Contig. Teeth Or Bounded Teeth Spaces, Per Quad
- D4211 Gingivectomy/Gingivoplasty-1 to 3 Teeth, Per Quadrant
- D4240 Gingival Flap Incl Root Planing-4 Or More Contig. T Or Bounded T Spaces Per Quad.
- D4241 Gingival Flap Incl Root Planing-1 to 3 Teeth Per Quadrant
- D4249 Clinical Crown Lengthening-Hard Tissue
- D4260 Osseous Surgery (Inc Flap Entry & Clos)-4 or More Contig. T Or Bounded T Spaces Per Quad
- D4261 Osseous Surgery (Inc Flap Entry & Clos)-1 to 3 Teeth, per Quadrant
- D4263 Bone Replacement Graft-First Site In Quadrant
- D4264 Bone Replace Graft-Each Add'l Site In Quad
- D4266 Guided Tiss Regen-Resorbable Barrier, Per T
- D4267 Guided Tissue Regen-Nonresorbable Barrier
- D4270 Pedicle Soft Tissue Graft Procedure
- D4271 Free Soft Tissue Graft (Incl Donor Site Surg)
- D4273 Subepith Conn Tiss Graft Proc
- D4275 Soft Tissue Allograft
- D4276 Combine Connective Tissue and Double Pedicle Graft
- D4341 Periodontal Scaling And Root Planing-4 or More Contig T Or Bounded T Spaces, Per Quad
- D4342 Periodontal Scaling And Root Planing-1 to 3 Teeth, Per Quadrant
- D4910 Periodontal Maintenance

Prosthodontics - Removable

- D5110 Complete Denture-Upper
- D5120 Complete Denture-Lower
- D5130 Immediate Denture-Upper
- D5140 Immediate Denture-Lower
- D5211 Upper Partial-Resin (Incl Clsps, Rests & Teeth)
- D5212 Lower Partial-Resin (Incl Clsps, Rests & Teeth)
- D5213 Upper Partial-Cast Metal W/Res(Incl C, R & T)
- D5214 Lower Partial-Cast Metal W/Res(Incl C, R & T)
- D5225 Maxillary Partial Denture-Flexible Base
- D5226 Mandibular Partial Denture-Flexible Base
- D5281 Remove Uni Partial-Pc Cast Metal(Incl C, & T)
- D5510 Repair Broken Complete Denture Base
- D5520 Replace Missing/Broken Teeth-Complete Denture (Each)
- 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
- D5670 Replace Teeth & Acrylic on Cast Metal Frame, Upper
- D5671 Replace Teeth & Acrylic on Cast Metal Frame, Lower
- D5710 Rebase Complete Upper Denture
- D5711 Rebase Complete Lower Denture

- D5720 Rebase Upper Partial Denture
- D5721 Rebase Lower Partial Denture
- D5730 Reline Complete Upper Denture (Chairside)
- D5731 Reline Complete Lower Denture (Chairside)
- D5740 Reline Upper Partial Denture (Chairside)
- D5741 Reline Lower Partial Denture (Chairside)
- D5750 Reline Complete Upper Denture (Laboratory)
- D5751 Reline Complete Lower Denture (Laboratory)
- D5760 Reline Upper Partial Denture (Laboratory)
- D5761 Reline Lower Partial Denture (Laboratory)
- D5850 Tissue Conditioning, Upper
- D5851 Tissue Conditioning, Lower

Prosthodontics - Fixed

- D6205 Pontic-Indirect Resin Based Composite
- *D6210 Pontic-Cast High Noble Metal
- D6211 Pontic-Cast Predominantly Base Metal
- *D6212 Pontic-Cast Noble Metal
- *D6240 Pontic-Porcelain Fused To High Noble Metal
- D6241 Pontic-Porcelain Fused To Predom Base Metal
- *D6242 Pontic-Porcelain Fused To Noble Metal
- D6251 Pontic-Resin With Predominantly Base Metal
- D6600 Inlay-Porcelain/Ceramic, 2 Surfaces
- D6601 Inlay-Porcelain/Ceramic, 3 Or More Surfaces
- *D6602 Inlay-Cast High Noble Metal, 2 Surfaces
- *D6603 Inlay-Cast High Noble Metal, 3 Or More Surf
- D6604 Inlay-Cast Predominantly Base Metal, 2 Surf
- D6605 Inlay-Cast Predom Base Metal, 3 Or More Surf
- *D6606 Inlay-Cast Noble Metal, 2 Surfaces
- *D6607 Inlay-Cast Noble Metal, 3 Or More Surfaces
- D6608 Onlay-Porcelain/Ceramic, 2 Surfaces
- D6609 Onlay-Porcelain/Ceramic, 3 Or More Surfaces
- *D6610 Onlay-Cast High Noble Metal, 2 Surfaces
- *D6611 Onlay-Cast High Noble Metal, 3 Or More Surf
- D6612 Onlay-Cast Predominately Base Metal, 2 Surf
- D6613 Onlay-Cast Predom Base Metal, 3 Or More Surf
- *D6614 Onlay-Cast Noble Metal, 2 Surfaces
- *D6615 Onlay-Cast Noble Metal, 3 Or More Surfaces
- D6710 Crown-Indirect Resin Based Composite
- D6721 Crown-Resin With Predominantly Base Metal
- *D6750 Crown-Porcelain Fused To High Noble Metal
- D6751 Crown-Porcelain Fused To Predom Base Metal
- *D6752 Crown-Porcelain Fused To Noble Metal
- D6781 Crown-¾ Cast Predominately Base Metal
- *D6790 Crown-Full Cast High Noble Metal
- D6791 Crown-Full Cast Predom Base Metal
- *D6792 Crown-Full Cast Noble Metal
- D6930 Recement Fixed Partial Denture

Oral Surgery

- D7220 Removal Of Impacted Tooth Soft Tissue
- D7230 Removal Of Impacted Tooth Partially Bony
- D7240 Removal Of Impacted Tooth Complete Bony

Miscellaneous

- D9220 General Anesthesia-First 30 Min.
- D9221 General Anesthesia-Each Add 15 Min.

Class D - No Deductible, 24-Month Waiting Period, Limited To Covered Child

Orthodontics

- D8070 Comprehensive Orthodontic Treatment Of The Transitional Dentition
- D8080 Comprehensive Orthodontic Treatment Of The Adolescent Dentition

Claim Provisions

How to File Claims

Bills and receipts should be itemized and show:

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

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

GEHA CONNECTION Dental *Plus*
P.O. Box 400
Independence, MO 64051-0400

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

If you need help in filing your claim, call us toll-free at (800) 793-9335, or TDD (800) 821-4833.

Keep a separate record of the dental expenses of each Covered Person, as Deductibles and Maximum Benefit Limits apply separately to each Covered Person. Save copies of all dental bills, including those you accumulate to satisfy a Deductible. In most instances, they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

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

supporting documentation such as clinical reports, charts, X-rays and study models.

Examination

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

Payment of Benefits

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

- To any assignee of record; otherwise
- To you, if living; otherwise
- To your estate.

Facility of Payment

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.

Assignment of Benefits

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

Type of Claim

Claims for benefits under the Plan are deemed to be Post-Service claims as defined by ERISA, and shall be adjudicated in the manner required by ERISA for Post-Service claims.

Notification of Claim Decision

You will be notified of our decision on your claim within a reasonable period of time, but no later than 30 days after receipt of your claim. If we determine that an extension of time is necessary due to matters beyond The Dental Plan's control, we may extend this 30-day period by up to 15 days. If this happens, we will notify 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.

Claim Provisions *continued*

If an extension is due to your failure to submit the information needed for us 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 Dental 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 we take another final action, the Covered Person will be advised of the following:

- The specific reason for the denial;
- Specific reference to The Dental Plan provisions on which the denial is based;
- 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 description of your right to file suit in court if your request for review is denied.

If we 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. Similarly, if your claim was denied on the basis of dental necessity or an experimental treatment or similar exclusion or limit, the notice will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of The Dental Plan to your circumstances, or a statement that such an explanation 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 by us, you, or an authorized representative acting on your behalf, shall have the right to request that we review the benefit denial or other action. For an authorized representative to act on your behalf The Dental Plan must receive an Appointment of Authorized Representative form signed by you. Such form can be obtained and submitted to the Plan Administrator. 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. The Dental Plan provides a two-level appeal system that allows you full opportunity to appeal benefit decisions.

Level 1: Reconsideration

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 us 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 may 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 reason for the request, a copy of the initial determination and any supporting documentation such as X-rays, provider narrative or office notes. Request for reconsideration should be sent to:

CONNECTION Dental *Plus* Appeals
P. O. Box 455
Independence, MO 64051-0455

The request for reconsideration will be treated as received by The Dental Plan (a) 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.

Claim Provisions *continued*

Within thirty (30) days after we receive your request for reconsideration, the review will be made. Someone other than the person who processed or reviewed the original claim shall make the review of 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, we will consult with a health care professional having appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will be different from any individual consulted in connection with the original claim decision, and will not be a subordinate of any such individual. If The Dental Plan obtained advice from any medical experts in making a decision on 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 decision on our review will be forwarded to you in writing and will include specific reasons for the decisions, references to provisions upon which the decision was based, further appeal rights and a statement of your right to file suit in court to obtain payment of your claim for benefits.

If we 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 dental necessity or an experimental treatment or similar exclusion or limit, the notice will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of The Dental Plan to 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 expert will be provided to you upon request, regardless of whether the advice was relied on by the Plan.

Level 2: Formal Review

If a claim remains denied after a request for reconsideration, you, or an authorized representative acting on your behalf, shall have the right to request a formal review of the denial or other action. To request a formal review of a claim denial or other action, you must file a written request for formal review postmarked within one hundred and eighty (180) days after the date of our reconsideration response. Failure to comply with this important deadline may 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 made in writing and include the reason for the request for formal review, copy of our reconsideration request letter and any new information. Requests for formal review should be sent to:

CONNECTION Dental *Plus* Appeals
P. O. Box 455
Independence, MO 64051-0455

The request for reconsideration will be treated as received by The Dental Plan (a) 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 thirty (30) days after we receive your request for formal review, the review shall be made. Someone other than the person(s) who processed or reviewed the earlier reconsideration request shall review all documents submitted to The Dental Plan and no deference will be given to any prior decision. The formal review will take into account all information submitted by you, regardless of whether or not the information was available or presented at a former benefits decision.

If the denial was based, in whole or in part, on any medical judgment, we will consult with a health care professional having appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will be different from any individual consulted in connection with the original claim decision, and will not be a subordinate of any such individual. If The Dental Plan obtained advice from any medical experts in making a decision on 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.

Claim Provisions *continued*

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

If we relied on an internal rule, guideline, protocol or other similar criterion in denying your request for formal review, 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 formal review was denied on the basis of dental necessity or an experimental treatment or similar exclusion or limit, the notice will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of The Dental Plan to your circumstances, or a statement that such an explanation will be provided to you free of charge upon your request.

Standard of Review

The decision of the Named Fiduciary 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 the Named Fiduciary shall be based only on such evidence presented to or considered by the Named Fiduciary 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 the Named Fiduciary 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 Dental Plan until the review procedure has been exhausted as described above.

Benefit Schedule

Do not rely on this chart alone. All benefits are subject to the definitions, limitations and exclusions set forth in the dental brochure.

Covered Services	Calendar Year Deductible	Waiting Period	Provider Participation	Benefit
Class A Specified Diagnostic and Preventive	\$0	None	In-network Out-of-network	100% 80%
Class B Other Diagnostic, Preventive, Restorative & Specified Oral Surgery	\$50	None	In-network Out-of-network	80% 70%
Class C Endodontics, Periodontics, Prosthodontics and Crowns, Inlays, Onlays,	\$100	12-month	In-network Out-of-network	50% 40%
Class D Orthodontics- Comprehensive Case	\$0	24-month	In-network Out-of-network	\$50 per month \$25 per month

Deductibles

- Calendar Year Deductibles apply separately to Class B and Class C Covered Services. The Class B Deductible does not apply to or reduce the Class C Deductible.
- Deductibles apply separately to each Covered Person.

Maximum Limits

- Class A, Class B and Class C Covered Services have a combined Calendar Year Maximum Benefit Limit per Covered Person of \$1,200.
- Class D Covered Services have a Calendar Year Maximum Benefit Limit of \$600 per Covered Child for treatment by a Participating Provider or \$300 for treatment by a Non-participating Provider and a Lifetime Maximum Benefit Limit of \$1,200 per Covered Child toward treatment by a Participating Provider or \$600 for treatment by a Non-participating Provider.

Waiting Periods

- Waiting Periods apply separately to each Covered Person. If an Eligible Dependent's Effective Date of Coverage is later than the Member's Effective Date of Coverage, the Waiting Period for the Eligible Dependent begins on the Effective Date of Coverage for the Eligible Dependent.
- Coverage for Class C Covered Services begins 12 months after the date the Member or Eligible Dependent is first covered under The Dental Plan.
- Coverage for Class D Covered Services begins 24 months after the date the Covered Child is first covered under The Dental Plan.

Benefit Percentages

- Benefit Percentages apply separately to each Covered Person. If an Eligible Dependent's Effective Date of Coverage is later than the Member's Effective Date of Coverage, the Benefit Percentages for the Eligible Dependent begin on the Effective Date of Coverage for the Eligible Dependent.