GEHA Connection Dental Plus

Summary of Material Modifications

This Summary of Material Modifications (SMM) supplements the Summary of Benefits and Coverage (SBC) and Summary Plan Description (SPD), for the Government Employees Health Associations, Inc. Voluntary Dental Plan, also known as GEHA Connection Dental Plus (The Dental Plan). The SBC and SPD is also known as the Plan Brochure distributed to you in September 2013. This SMM and the SPD should be reviewed together. For an additional copy of the SPD, please call us at 800-793-9335 or contact us at P. O. Box 400, Independence, MO 64051-400. These changes are effective January 1, 2016. The following Plan's provisions during the Plan Year have been amended to read as follows:

Cover Page, URAC, added the URAC accreditation seal.

Page 2, Child, changed definition of child:
Child includes only:
• Your natural child, stepchild or adopted child; and
• Your 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.

Page 3, Agent for Service of Legal Process, changed name and address of contact:
CT Corporation System
120 South Central Avenue
Clayton, MO 63105

Page 3, Named Fiduciary and Contact Information, changed name of contact:
GEHA Board of Directors
GEHA Connection Dental Plus
P.O. Box 400
Independence, MO 64051-0400
(800) 793-9335

Page 18, Coordination of Benefits, added examples, updated language:
There is no change in benefit limits or maximums when we are the secondary payor.
For example:

<table>
<thead>
<tr>
<th>Other Dental Coverage</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge</td>
<td>$165.00</td>
</tr>
<tr>
<td>Covered Expense</td>
<td>$139.00 ($165-$26 difference)</td>
</tr>
<tr>
<td>Other Dental Coverage Payment</td>
<td>$23.00</td>
</tr>
<tr>
<td>GEHA’s Regular Benefit</td>
<td>$111.20 ($139 x 80%)</td>
</tr>
<tr>
<td>GEHA’s Payment</td>
<td>$111.20</td>
</tr>
<tr>
<td>Patient’s Responsibility</td>
<td>$4.80</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Other Dental Coverage</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge</td>
<td>$31.00</td>
</tr>
<tr>
<td>Covered Expense</td>
<td>$29.00 ($31-$2 difference)</td>
</tr>
<tr>
<td>Other Dental Coverage Payment</td>
<td>$8.00</td>
</tr>
<tr>
<td>GEHA’s Regular Benefit</td>
<td>$29.00 ($29 x 100%)</td>
</tr>
<tr>
<td>GEHA’s Payment</td>
<td>$21.00</td>
</tr>
<tr>
<td>Patient’s Responsibility</td>
<td>$2.00</td>
</tr>
</tbody>
</table>
You are responsible for the $2.00 difference between the charge and the covered expense, when you use an out-of-network dentist. The dentist can bill you for the difference.

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

**Page 22, Class B**, removed part of limitation under Fillings:
- Fillings – limited to one restoration per tooth surface every two Calendar Years.

**Page 22, Class C**, added limitation:
- Gingivectomy, gingivoplasty, gingival flap procedure, and osseous surgery are limited to once per quadrant every 2 Calendar Years.
- Tissue graft procedures are not covered when treating implants or in edentulous areas.
- Scaling in presence of generalized moderate or severe gingival inflammation limited to once every three Calendar Years.

**Page 24, Services Not Covered**, updated language #14:
Services or treatment for which no charge (or the patient has no responsibility to pay) would be made in absence of this coverage including, but not limited to, discounts, disallow due to negotiated rate and provider write-off amounts.

**Page 24 - 27, Covered Service List**, updated codes and language:

<table>
<thead>
<tr>
<th>Covered Services List</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Services List</strong></td>
</tr>
<tr>
<td>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. <strong>Current Dental Terminology © American Dental Association.</strong></td>
</tr>
<tr>
<td><strong>Class A - No deductible, No Waiting Period</strong></td>
</tr>
<tr>
<td>Diagnostic</td>
</tr>
<tr>
<td>D0120 Periodic Oral Evaluation–Established Patient</td>
</tr>
<tr>
<td>D0140 Limited Oral Evaluation-Problem Focused</td>
</tr>
<tr>
<td>D0145 Oral Evaluation for a Patient Under 3 Years of Age and Counseling with Primary Caregiver</td>
</tr>
<tr>
<td>D0150 Comprehensive Oral Evaluation–New or Established Patient</td>
</tr>
<tr>
<td>D0180 Comprehensive Periodontal Evaluation–New or Established Patient</td>
</tr>
<tr>
<td>D0270 Bitewing-Single Radiographic Image</td>
</tr>
<tr>
<td>D0272 Bitewings-2 Radiographic Images</td>
</tr>
<tr>
<td>D0273 Bitewings-3 Radiographic Images</td>
</tr>
<tr>
<td>D0274 Bitewings-4 Radiographic Images</td>
</tr>
<tr>
<td>D0277 Vertical Bitewings-7 to 8 Radiographic Images</td>
</tr>
<tr>
<td>Preventive</td>
</tr>
<tr>
<td>D1110 Prophylaxis Adult</td>
</tr>
<tr>
<td>D1120 Prophylaxis Child</td>
</tr>
<tr>
<td>*D1206 Topical Application of Fluoride Varnish</td>
</tr>
<tr>
<td>*D1208 Topical Application of Fluoride – excluding Varnish</td>
</tr>
<tr>
<td><strong>Class B - $50 Calendar Year Deductible</strong></td>
</tr>
<tr>
<td>Per Person, No Waiting Period</td>
</tr>
<tr>
<td>Diagnostic</td>
</tr>
<tr>
<td>D0120 Intraoral-Complete Series of Radiographic Images</td>
</tr>
<tr>
<td>D0220 Intraoral-Periapical-First Radiographic Image</td>
</tr>
<tr>
<td>D0230 Intraoral-Periapical-each additional Radiographic Image</td>
</tr>
<tr>
<td>D0330 Panoramic Radiographic Image</td>
</tr>
<tr>
<td>Preventive</td>
</tr>
<tr>
<td>D1351 Sealant-Per Tooth</td>
</tr>
<tr>
<td>D1354 Interim Caries Arresting Medicament Application</td>
</tr>
<tr>
<td>D1510 Space Maintainer-Fixed Unilateral</td>
</tr>
<tr>
<td>D1515 Space Maintainer-Fixed Bilateral</td>
</tr>
<tr>
<td>D1520 Space Maintainer-Removable Unilateral</td>
</tr>
<tr>
<td>D1525 Space Maintainer-Removable Bilateral</td>
</tr>
<tr>
<td>D1575 Distal Shoe Space Maintainer – Fixed - Unilateral</td>
</tr>
<tr>
<td>Restorative</td>
</tr>
<tr>
<td>D1352 Preventive Resin Restoration in a Moderate to High Caries Risk Patient–Permanent Tooth</td>
</tr>
<tr>
<td>D2140 Amalgam-1 Surface, Primary or Permanent</td>
</tr>
<tr>
<td>D2150 Amalgam-2 Surfaces, Primary or Permanent</td>
</tr>
<tr>
<td>D2160 Amalgam-3 Surfaces, Primary or Permanent</td>
</tr>
<tr>
<td>D2161 Amalgam-4 or More Surfaces, Primary or Permanent</td>
</tr>
<tr>
<td>D2330 Resin-Based Composite 1 Surface, Anterior</td>
</tr>
<tr>
<td>D2331 Resin-Based Composite 2 Surfaces, Anterior</td>
</tr>
<tr>
<td>D2332 Resin-Based Composite 3 Surfaces, Anterior</td>
</tr>
</tbody>
</table>
Covered Services List continued

D2335 Resin-Based Composite 4 or More Surfaces or Involving Incisal Angle, (Anterior)
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
*D2929 Prefabricated Porcelain/Ceramic Crown–Primary Tooth
D2930 Prefabricated Stainless Steel Crown–Primary Tooth
D2934 Prefabricated Esthetic Coated Stainless Steel Crown–Primary Tooth
D2951 Pin Retention-Per Tooth, in Addition to Restoration

Restorative
D2390 Resin-Based Composite Crown, Anterior

Prosthodontics – Removable
D5410 Adjust Complete Denture-Maxillary
D5411 Adjust Complete Denture-Mandibular
D5421 Adjust Partial Denture-Maxillary
D5422 Adjust Partial Denture-Mandibular

D5420 Adjust Partial Denture-Maxillary
D5422 Adjust Partial Denture-Mandibular

D5411 Adjust Complete Denture-Maxillary
D5422 Adjust Partial Denture-Mandibular

Prosthodontics – Removable
D5410 Adjust Complete Denture-Maxillary
D5411 Adjust Complete Denture-Mandibular
D5421 Adjust Partial Denture-Maxillary
D5422 Adjust Partial Denture-Mandibular

D5420 Adjust Partial Denture-Maxillary
D5422 Adjust Partial Denture-Mandibular

D5411 Adjust Complete Denture-Maxillary
D5422 Adjust Partial Denture-Mandibular

Oral Surgery
D7111 Extraction, Coronal Remnants-Deciduous Tooth
D7140 Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)

D7210 Extraction, Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth, and Including Elevation of Mucoperiosteal Flap if Indicated

D7250 Removal of Residual Tooth Roots-(Cutting)
D7310 Alveolectomy in Conjunction with Extractions-4 or More Teeth or Tooth Spaces, Per Quadrant
D7311 Alveolectomy in Conjunction with Extractions 1 to 3 Teeth or Tooth Spaces, Per Quadrant
D7320 Alveolectomy Not in Conjunction with Extractions-4 or More Teeth or Tooth Spaces, Per Quadrant
D7321 Alveolectomy not in Conjunction with Extractions-1 to 3 Teeth or Tooth Space, Per Quadrant
D7450 Removal of Benign Odontogenic Cyst or Tumor-Lesion Diameter Up to 1.25cm
D7510 Incision and Drainage of Abscess-Intraoral Soft Tissue
D7511 Incision and Drainage of Abscess-Intraoral Soft Tissue Complicated (includes drainage of multiple fascial spaces)
D7960 Frenulectomy-Also Known as Frenectomy or Frenotomy-Separate Procedure Not Incidental to Another Procedure
D7963 Frenulectomy
D7970 Excision of Hyperplastic Tissue - Per Arch
D7971 Excision of Pericoronal Gingiva

Miscellaneous
D9110 Palliative (ER) Treatment of Dental Pain-minor procedure
D9910 Application of Desensitizing Medicament

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

D2400 Onlay–Porcelain/Ceramic–3 Surfaces
*D2644 Onlay–Porcelain/Ceramic–4 or More Surfaces
*D2710 Crown-Resin-Based Composite (Indirect)
*D2712 Crown-½ Resin-Based Composite (Indirect)
*D2729 Crown-Resin with High Noble Metal
*D2721 Crown-Resin with Predominantly Base Metal
*D2722 Crown-Resin with Base Metal
*D2740 Crown-Porcelain/Ceramic Substrate

*D2750 Crown-Porcelain Fused to High Noble Metal
D2751 Crown-Porcelain Fused to Predominantly Base Metal
*D2752 Crown-Porcelain Fused to Noble Metal
D2781 Crown-½ Cast Predominately Base Metal
*D2790 Crown-Full Cast High Noble Metal
D2791 Crown-Full Cast Predominantly Base Metal
*D2792 Crown-Full Cast Noble Metal
D2910 Re-cement or Re-bond Inlay, Onlay, Veneer or Partial Coverage Restoration
D2915 Re-cement or Re-bond indirectly Fabricated or Prefabricated Post and Core
D2920 Re-cement or Re-bond Crown
D2940 Protective Restoration
D2950 Core Buildup, Including Any Pins When Required
*D2952 Post and Core In addition to Crown, Indirectly Fabricated
*D2953 Each Additional Indirectly Fabricated Post – Same Tooth
D2954 Prefabricated Post and Core in Addition to Crown
D2957 Each Additional Prefabricated Post - Same Tooth

Endodontics
D3110 Pulp Cap - Direct (Excluding Final Restoration)
D3220 Therapeutic Pulpotomy (Excluding Final Restoration) - Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament
D3221 Pulpal Debridement, Primary and Permanent Teeth
D3222 Partial pulpotomy For Apexogenesis – Permanent Tooth with Incomplete Root Development
D3310 Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)
D3320 Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)
D3330 Endodontic Therapy, Molar (Excluding Final Restoration)
D3346 Retreatment of Previous Root Canal Therapy - Anterior
D3347 Retreatment of Previous Root Canal Therapy - Bicuspid
D3348 Retreatment of Previous Root Canal Therapy - Molar
D3410 Apicoectomy - Anterior
D3421 Apicoectomy - Bicuspid (First Root)
D3425 Apicoectomy - Molar (First Root)
D3426 Apicoectomy (Each Additional Root)
D3430 Tooth in the Same Surgical Site

Periodontics
D4210 Gingivectomy or Gingivoplasty - 4 Or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant
D4211 Gingivectomy or Gingivoplasty - 1 to 3 Contiguous Teeth, Or Tooth Bounded Spaces Per Quadrant
D4240 Gingival Flap Procedure, Including Root Planing - 4 or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant
D4241 Gingival Flap Procedure, Including Root Planing - 1 to 3 Contiguous Teeth or Tooth Bounded Spaces Per Quadrant
D4249 Clinical Crown Lengthening - Hard Tissue
D4260 Osseous Surgery (Including Elevation of a Full Thickness Flap and Closure) - 4 or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant
D4261 Osseous Surgery (Including Elevation of a Full Thickness Flap and Closure) - 1 to 3 Contiguous Teeth or Tooth Bounded Spaces Per Quadrant

3 of 5
Covered Services List continued

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4263</td>
<td>Bone Replacement Graft – Retained Natural Tooth - First Site in Quadrant</td>
</tr>
<tr>
<td>D4264</td>
<td>Bone Replacement Graft - Retained Natural Tooth - Each Additional Site in Quadrant</td>
</tr>
<tr>
<td>D4266</td>
<td>Guided Tissue Regeneration - Resorbable Barrier, Per Site</td>
</tr>
<tr>
<td>D4267</td>
<td>Guided Tissue Regeneration – Non-resorbable Barrier, Per Site (Including Membrane Removal)</td>
</tr>
<tr>
<td>D4270</td>
<td>Pedicle Soft Tissue Graft Procedure</td>
</tr>
<tr>
<td>D4273</td>
<td>Autogenous Connective Tissue Graft Procedure, (Including Donor and Recipient Surgical Sites) First Tooth, Implant or Edentulous Tooth Position in Graft</td>
</tr>
<tr>
<td>D4275</td>
<td>Non-Autogenous Connective Tissue Graft (Including Recipient Site and Donor Material) First Tooth, Implant, or Edentulous Tooth Position in Graft</td>
</tr>
<tr>
<td>D4276</td>
<td>Combined Connective Tissue and Double Pedicle Graft, Per Tooth</td>
</tr>
<tr>
<td>D4277</td>
<td>Free Soft Tissue Graft Procedure (Including Recipient and Donor Surgical Sites) First Tooth, Implant, or Edentulous Tooth Position in Graft</td>
</tr>
<tr>
<td>D4278</td>
<td>Free Soft Tissue Graft Procedure (Including Recipient and Donor Surgical Sites) Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site</td>
</tr>
<tr>
<td>D4283</td>
<td>Autogenous Connective Tissue Graft Procedure (Including Donor and Recipient Surgical Sites) – Each Additional Contiguous tooth, Implant or Edentulous Tooth Position in Same Graft Site</td>
</tr>
<tr>
<td>D4285</td>
<td>Non-Autogenous Connective Tissue Graft Procedure (Including Recipient Surgical Site and Donor Material) Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site</td>
</tr>
<tr>
<td>D4341</td>
<td>Periodontal Scaling and Root Planing - 4 or More Teeth Per Quadrant</td>
</tr>
<tr>
<td>D4342</td>
<td>Periodontal Scaling and Root Planing - 1 to 3 Teeth, Per Quadrant</td>
</tr>
<tr>
<td>D4346</td>
<td>Scaling in Presence of Generalized Moderate or Severe Gingival Inflammation – Full Mouth, After Oral Evaluation</td>
</tr>
<tr>
<td>D4910</td>
<td>Periodontal Maintenance</td>
</tr>
</tbody>
</table>

**Prosthodontics - Removable**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>Complete Denture - Maxillary</td>
</tr>
<tr>
<td>D5120</td>
<td>Complete Denture - Mandibular</td>
</tr>
<tr>
<td>D5130</td>
<td>Immediate Denture -- Maxillary</td>
</tr>
<tr>
<td>D5140</td>
<td>Immediate Denture - Mandibular</td>
</tr>
<tr>
<td>D5211</td>
<td>Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5212</td>
<td>Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5213</td>
<td>Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5214</td>
<td>Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5221</td>
<td>Immediate Maxillary Partial Denture – Resin Base (Including Any Conventional Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5222</td>
<td>Immediate Mandibular Partial Denture – Resin Base (Including Any Conventional Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5223</td>
<td>Immediate Maxillary Partial Denture – Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5224</td>
<td>Immediate Mandibular Partial Denture – Case Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5225</td>
<td>Maxillary Partial Denture - Flexible Base (Including Any Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5226</td>
<td>Mandibular Partial Denture - Flexible Base (Including Any Clasp, Rests and Teeth)</td>
</tr>
<tr>
<td>D5281</td>
<td>Removable Unilateral Partial Denture - 1 Piece Cast Metal (Including Clasps and Teeth)</td>
</tr>
<tr>
<td>D5510</td>
<td>Repair Broken Complete Denture Base</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace Missing or Broken Teeth - Complete Denture (Each Tooth)</td>
</tr>
<tr>
<td>D5610</td>
<td>Repair Resin Denture Base</td>
</tr>
<tr>
<td>D5620</td>
<td>Repair Cast Framework</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or Replace Broken Clasp – Per Tooth</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace Broken Teeth - Per Tooth</td>
</tr>
<tr>
<td>D5650</td>
<td>Add Tooth to Existing Partial Denture</td>
</tr>
<tr>
<td>D5660</td>
<td>Add Clasp to Existing Partial Denture – Per Tooth</td>
</tr>
<tr>
<td>D5670</td>
<td>Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary)</td>
</tr>
<tr>
<td>D5671</td>
<td>Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular)</td>
</tr>
<tr>
<td>D5710</td>
<td>Rebase Complete Maxillary Denture</td>
</tr>
<tr>
<td>D5711</td>
<td>Rebase Complete Mandibular Denture</td>
</tr>
<tr>
<td>D5720</td>
<td>Rebase Maxillary Partial Denture</td>
</tr>
<tr>
<td>D5721</td>
<td>Rebase Mandibular Partial Denture</td>
</tr>
<tr>
<td>D5730</td>
<td>Reline Complete Maxillary Denture (Chairside)</td>
</tr>
<tr>
<td>D5731</td>
<td>Reline Complete Mandibular Denture (Chairside)</td>
</tr>
<tr>
<td>D5740</td>
<td>Reline Maxillary Partial Denture (Chairside)</td>
</tr>
<tr>
<td>D5741</td>
<td>Reline Mandibular Partial Denture (Chairside)</td>
</tr>
<tr>
<td>D5750</td>
<td>Reline Complete Maxillary Denture (Laboratory)</td>
</tr>
<tr>
<td>D5751</td>
<td>Reline Complete Mandibular Denture (Laboratory)</td>
</tr>
<tr>
<td>D5760</td>
<td>Reline Maxillary Partial Denture (Laboratory)</td>
</tr>
<tr>
<td>D5761</td>
<td>Reline Mandibular Partial Denture (Laboratory)</td>
</tr>
<tr>
<td>D5780</td>
<td>Tissue Conditioning, Maxillary</td>
</tr>
<tr>
<td>D5781</td>
<td>Tissue Conditioning, Mandibular</td>
</tr>
</tbody>
</table>

**Prosthodontics - Fixed**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6205</td>
<td>Pontic - Indirect Resin Based Composite</td>
</tr>
<tr>
<td>D6210</td>
<td>Pontic - Cast High Noble Metal</td>
</tr>
<tr>
<td>D6211</td>
<td>Pontic - Cast Predominantly Base Metal</td>
</tr>
<tr>
<td>D6212</td>
<td>Pontic - Cast Noble Metal</td>
</tr>
<tr>
<td>D6240</td>
<td>Pontic - Porcelain Fused to High Noble Metal</td>
</tr>
<tr>
<td>D6241</td>
<td>Pontic - Porcelain Fused to Predominantly Base Metal</td>
</tr>
<tr>
<td>D6242</td>
<td>Pontic-Porcelain Fused to Noble Metal</td>
</tr>
<tr>
<td>D6245</td>
<td>Pontic - Porcelain/Ceramic</td>
</tr>
<tr>
<td>D6250</td>
<td>Pontic - Resin with High Noble Metal</td>
</tr>
<tr>
<td>D6251</td>
<td>Pontic - Resin with Predominantly Base Metal</td>
</tr>
<tr>
<td>D6252</td>
<td>Pontic - Resin with Noble Metal</td>
</tr>
<tr>
<td>D6600</td>
<td>Retainer Inlay - Porcelain/Ceramic, 2 Surfaces</td>
</tr>
</tbody>
</table>
Covered Services List continued

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6601</td>
<td>Retainer Inlay - Porcelain/Ceramic, 3 or More</td>
</tr>
<tr>
<td></td>
<td>Surfaces</td>
</tr>
<tr>
<td>*D6602</td>
<td>Retainer Inlay - Cast High Noble Metal, 2 Surfaces</td>
</tr>
<tr>
<td>*D6603</td>
<td>Retainer Inlay - Cast High Noble Metal, 3 or More</td>
</tr>
<tr>
<td></td>
<td>Surfaces</td>
</tr>
<tr>
<td>D6604</td>
<td>Retainer Inlay - Cast Predominantly Base Metal, 2</td>
</tr>
<tr>
<td></td>
<td>Surfaces</td>
</tr>
<tr>
<td>D6605</td>
<td>Retainer Inlay - Cast Predominantly Base Metal, 3</td>
</tr>
<tr>
<td></td>
<td>or More Surfaces</td>
</tr>
<tr>
<td>*D6606</td>
<td>Retainer Inlay - Cast Noble Metal, 2 Surfaces</td>
</tr>
<tr>
<td>*D6607</td>
<td>Retainer Inlay - Cast Noble Metal, 3 or More</td>
</tr>
<tr>
<td></td>
<td>Surfaces</td>
</tr>
<tr>
<td>D6608</td>
<td>Retainer Onlay - Porcelain/Ceramic, 2 Surfaces</td>
</tr>
<tr>
<td>D6609</td>
<td>Retainer Onlay - Porcelain/Ceramic, 3 or More</td>
</tr>
<tr>
<td></td>
<td>Surfaces</td>
</tr>
<tr>
<td>*D6610</td>
<td>Retainer Onlay - Cast High Noble Metal, 2 Surfaces</td>
</tr>
<tr>
<td>*D6611</td>
<td>Retainer Onlay - Cast High Noble Metal, 3 or More</td>
</tr>
<tr>
<td></td>
<td>Surfaces</td>
</tr>
<tr>
<td>D6612</td>
<td>Retainer Onlay - Cast Predominately Base Metal, 2</td>
</tr>
<tr>
<td></td>
<td>Surfaces</td>
</tr>
<tr>
<td>D6613</td>
<td>Retainer Onlay - Cast Predominately Base Metal, 3</td>
</tr>
<tr>
<td></td>
<td>or More Surfaces</td>
</tr>
<tr>
<td>*D6614</td>
<td>Retainer Onlay - Cast Noble Metal, 2 Surfaces</td>
</tr>
<tr>
<td>*D6615</td>
<td>Retainer Onlay - Cast Noble Metal, 3 or More</td>
</tr>
<tr>
<td></td>
<td>Surfaces</td>
</tr>
<tr>
<td>D6710</td>
<td>Retainer Crown - Indirect Resin Based Composite</td>
</tr>
<tr>
<td>*D6720</td>
<td>Retainer Crown - Resin with High Noble Metal</td>
</tr>
<tr>
<td>D6721</td>
<td>Retainer Crown - Resin with Predominantly Base</td>
</tr>
<tr>
<td></td>
<td>Metal</td>
</tr>
<tr>
<td>*D6722</td>
<td>Retainer Crown - Resin with Noble Metal</td>
</tr>
<tr>
<td>*D6740</td>
<td>Retainer Crown - Porcelain/Ceramic</td>
</tr>
<tr>
<td>*D6750</td>
<td>Retainer Crown - Porcelain Fused to High Noble</td>
</tr>
<tr>
<td></td>
<td>Metal</td>
</tr>
<tr>
<td>D6751</td>
<td>Retainer Crown - Porcelain Fused to Predominantly</td>
</tr>
<tr>
<td></td>
<td>Base Metal</td>
</tr>
<tr>
<td>*D6752</td>
<td>Retainer Crown - Porcelain Fused to Noble Metal</td>
</tr>
<tr>
<td>*D6780</td>
<td>Retainer Crown - ¾ Cast High Noble Metal</td>
</tr>
<tr>
<td>D6781</td>
<td>Retainer Crown - ¾ Cast Predominately Base Metal</td>
</tr>
<tr>
<td>*D6782</td>
<td>Retainer Crown - ¾ Cast Noble Metal</td>
</tr>
<tr>
<td>*D6783</td>
<td>Retainer Crown - ¾ Porcelain/Ceramic</td>
</tr>
<tr>
<td>*D6790</td>
<td>Retainer Crown - Full Cast High Noble Metal</td>
</tr>
<tr>
<td>D6791</td>
<td>Retainer Crown - Full Cast Predominantly Base</td>
</tr>
<tr>
<td></td>
<td>Metal</td>
</tr>
<tr>
<td>*D6792</td>
<td>Retainer Crown - Full Cast Noble Metal</td>
</tr>
<tr>
<td>D6930</td>
<td>Re-cement or Re-bond Fixed Partial Denture</td>
</tr>
</tbody>
</table>

### Oral Surgery

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

### Miscellaneous

- D9223 Deep Sedation/General Anesthesia - Each 15 Minute Increment

### Orthodontics

- D8070 Comprehensive Orthodontic Treatment of the Transitional Dentition
- D8080 Comprehensive Orthodontic Treatment of the Adolescent Dentition

---

**Page 31, Exhaustion of Remedies**: added limitation period for filing suit:

Unless specifically provided otherwise under a component benefit program or pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures.

**Premium Rates**: Your new Premium Rates (effective October 1, 2016) are on the back of this page.

---

**Plan Sponsor**: Government Employees Health Association, Inc.

**Sponsor's EIN**: 44-0545275

**Plan Name**: Government Employees Health Associations, Inc. Voluntary Dental Plan, also known as GEHA Connection Dental Plus

**Plan Year**: January 1–December 31

**Plan Number**: 601
Premium Rates

How to figure your monthly costs

1. In the first chart below, look up your state or zip code to determine your premium rate code.
2. In the second chart below, match your premium rate code to your membership status and coverage option (Self, Self+1 or Self + Family). GEHA Health Plan members should use the GEHA Health Plan Member section of the chart; participants not currently enrolled in a GEHA Health Plan should use the Dental Option Plan Member portion of the chart.

<table>
<thead>
<tr>
<th>State/Zip Code</th>
<th>Self Only</th>
<th>Self+1</th>
<th>Self+Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK 6</td>
<td>$21</td>
<td>$42</td>
<td>$63</td>
</tr>
<tr>
<td>AL 1</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>AR 2</td>
<td>$25</td>
<td>$50</td>
<td>$75</td>
</tr>
<tr>
<td>AZ 6</td>
<td>$28</td>
<td>$56</td>
<td>$84</td>
</tr>
<tr>
<td>CA 3</td>
<td>$31</td>
<td>$62</td>
<td>$93</td>
</tr>
<tr>
<td>CO 4</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
<tr>
<td>CT 6</td>
<td>$21</td>
<td>$42</td>
<td>$63</td>
</tr>
<tr>
<td>DC 4</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>DE 5</td>
<td>$25</td>
<td>$50</td>
<td>$75</td>
</tr>
<tr>
<td>FL 4</td>
<td>$28</td>
<td>$56</td>
<td>$84</td>
</tr>
<tr>
<td>GA 2</td>
<td>$31</td>
<td>$62</td>
<td>$93</td>
</tr>
<tr>
<td>HI 5</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
<tr>
<td>IA 1</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>ID 3</td>
<td>$25</td>
<td>$50</td>
<td>$75</td>
</tr>
<tr>
<td>IL 4</td>
<td>$28</td>
<td>$56</td>
<td>$84</td>
</tr>
<tr>
<td>IN 2</td>
<td>$31</td>
<td>$62</td>
<td>$93</td>
</tr>
<tr>
<td>KS 5</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
<tr>
<td>MO 4</td>
<td>$28</td>
<td>$56</td>
<td>$84</td>
</tr>
<tr>
<td>MS 3</td>
<td>$31</td>
<td>$62</td>
<td>$93</td>
</tr>
<tr>
<td>MT 2</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>NC 2</td>
<td>$25</td>
<td>$50</td>
<td>$75</td>
</tr>
<tr>
<td>ND 3</td>
<td>$31</td>
<td>$62</td>
<td>$93</td>
</tr>
<tr>
<td>NE 4</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
<tr>
<td>OH 3</td>
<td>$25</td>
<td>$50</td>
<td>$75</td>
</tr>
<tr>
<td>OK 1</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>OR 4</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
<tr>
<td>PA 2</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>RI 4</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
<tr>
<td>SC 2</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>SD 3</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
<tr>
<td>TN 2</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>TX 3</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
<tr>
<td>UT 3</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>VA 4</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
<tr>
<td>VT 4</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>WA 5</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
<tr>
<td>WI 3</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>WV 3</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
<tr>
<td>WI 2</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>WV 3</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
<tr>
<td>GU 2</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>PR 1</td>
<td>$24</td>
<td>$48</td>
<td>$72</td>
</tr>
<tr>
<td>VI 2</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
<tr>
<td>All Other Areas</td>
<td>$35</td>
<td>$70</td>
<td>$105</td>
</tr>
</tbody>
</table>

*Dental Premium – Monthly Cost*

<table>
<thead>
<tr>
<th>PREMIUM RATE SCHEDULE</th>
<th>GEHA Health Plan Members</th>
<th>Dental Option Plan Members**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self Only</td>
<td>Self+1</td>
</tr>
<tr>
<td>1</td>
<td>$21</td>
<td>$42</td>
</tr>
<tr>
<td>2</td>
<td>$31</td>
<td>$62</td>
</tr>
<tr>
<td>3</td>
<td>$39</td>
<td>$78</td>
</tr>
<tr>
<td>4</td>
<td>$44</td>
<td>$88</td>
</tr>
</tbody>
</table>

*Rates based on member’s primary state of residence.

**Dental Option Plan Members are participants who are not currently enrolled in the GEHA Health Plan.

GEHA’s supplemental dental benefits are neither offered nor guaranteed under contract with the FEHB program, but are made available to GEHA health plan members and all federal employees eligible for FEHB benefits.
Enrollment Kit

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.

THIS ENROLLMENT KIT INCLUDES:
• Summary of benefits and covered services
• Rates
• Enrollment application
• Dental plan brochure
• Bank draft authorization form
• Postage-paid envelope

ENROLL ONLINE AT: geha.com/cdplus
This page was intentionally left blank.
Thank you for your interest in Connection Dental Plus.

Connection Dental Plus, GEHA’s supplemental dental plan, provides coverage for a full range of dental services. Benefits are higher when you see a dentist in the Connection Dental® Network, which has grown to more than 123,000 provider locations nationwide. Enrollment in the Connection Dental Plus plan is open year-round to all current and former FEHB eligible federal employees – including those who do not join a GEHA health plan. Eligible dependents include your legally married spouse and each unmarried child who is under age 26.

This kit contains the current rates, plan benefits, enrollment form and bank draft authorization. To enroll, simply fill out the enclosed enrollment application and return it with your first month premium payment in the enclosed envelope. You can also enroll online. Visit geha.com/cdplus for enrollment forms and other online tools for the dental plan.

Note: Connection Dental Plus is not offered by the Office of Personnel Management (OPM) and is not part of the Federal Employees Health Benefits Program (FEHBP). For information on our OPM-approved Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan, go to GEHA Connection Dental Federal® online at gehadental.com or call (877) GEHA-DEN.
This page was intentionally left blank.
Plan on a healthy smile with
Connection Dental Plus

Comprehensive coverage

Connection Dental Plus offers benefits for a full range of dental services. When you see a network dentist, you receive benefits for 100 percent of covered preventive care services such as oral exams, routine cleanings, bitewing X-rays and fluoride for children. This plan also includes benefits for crowns, root canals, orthodontia and other dental services. Enrollment is open year-round to any eligible current or former federal employee, or retiree, not just members of GEHA health plans.

Connection Dental Plus coverage includes four classes of dental services – Classes A, B, C and D. See the chart below for waiting periods, deductibles and benefit percentages for each class. Calendar year deductibles apply separately to each covered individual and are calculated separately for each class of service. For example, expenses incurred for services in Class B do not apply to nor reduce the deductible for services in Class C. Covered services for Class A, Class B and Class C have a combined calendar year maximum limit of $1,200 for each covered person. Through network providers, Class D (orthodontia) has a calendar year maximum benefit limit of $600 per covered child and a lifetime benefit of $1,200 per covered child ages 6 through 17.

If you have other insurance, that insurance pays benefits before Connection Dental Plus pays. You must submit the other carrier’s Explanation of Benefits form to Connection Dental Plus to receive benefits from our plan.

Cost savings at more than 123,000 dentists in our growing network

Connection Dental Plus pays benefits for any dentist, but you may enjoy extra savings when you see a dentist in our network. At a network dentist, charges are limited to the maximum allowable charge for the area. Out-of-network dentists do not have to limit their charges to the maximum allowable, and may bill you for the difference if their regular fees are higher. Benefit percentages apply to the maximum allowable charge after deductibles are considered.

### Benefit Schedule

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>CALENDAR YEAR DEDUCTIBLE</th>
<th>WAITING PERIOD</th>
<th>PROVIDER PARTICIPATION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class A Specified Diagnostic and Preventive</td>
<td>$0</td>
<td>None</td>
<td>In-network</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Out-of-network</td>
<td>80%</td>
</tr>
<tr>
<td>Class B Other Diagnostic, Preventive, Restorative &amp; Specified Oral Surgery</td>
<td>$50</td>
<td>None</td>
<td>In-network</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Out-of-network</td>
<td>70%</td>
</tr>
<tr>
<td>Class C Endodontics, Periodontics, Prosthodontics &amp; Crowns, Inlays, Onlays</td>
<td>$100</td>
<td>12-month</td>
<td>In-network</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Out-of-network</td>
<td>40%</td>
</tr>
<tr>
<td>Class D Orthodontics - Comprehensive Case</td>
<td>$0</td>
<td>24-month</td>
<td>In-network</td>
<td>$50 per month</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Out-of-network</td>
<td>$25 per month</td>
</tr>
</tbody>
</table>
How to enroll in Connection Dental  

Choose one of three coverage options:

A. Self Only  
B. Self and One Dependent  
C. Self and Family

To enroll, you must currently or previously be eligible for FEHB benefits. Eligible dependents can be enrolled only if the current or former federal employee or annuitant enrolls. Eligible dependents are your legally married spouse and each unmarried child who is under age 26.

It’s easy to enroll:

1. Complete the Enrollment Application in this brochure.
2. Select your payment option:
   - monthly/quarterly bank draft from checking or savings account.
   - quarterly, semi annually or annually billing by GEHA.
3. Enclose a check or money order payable to GEHA Connection Dental Plus for your first month premium payment. (This is required even when choosing bank draft.) Refer to the Premium Rate Codes by State/Zip Code.
4. If you choose to pay by bank draft, complete the Bank Draft Authorization Form on page 5 of this brochure.
5. If you choose to be billed by GEHA, you may pay by check, credit card, or money order. We will send your statement on a quarterly basis.

Return your completed Enrollment Application (page 3), your first premium payment and your Bank Draft Authorization Form (if applicable) in the enclosed postage-paid envelope.

How to find an in-network dentist:

1) Visit geha.com/search.
2) Click Find a Dentist.
3) After completing the required information, a list of in-network dentists will display.
4) Or, call our Customer Service Department at (800) 296-0776 to request a list.

When coverage takes effect

If you meet all enrollment requirements, your coverage will be effective on the first day of the month following receipt of your Enrollment Application and first month premium payment by check, credit card, or money order.

After enrollment

1) After we process your Enrollment Application, we will mail your Connection Dental Plus identification cards to you.
2) Always present your Connection Dental Plus identification card to the dentist before you receive care.
3) Your card will show the claim filing address and important toll-free numbers for you and your dentist.
**ENROLLMENT APPLICATION**

**INSTRUCTIONS:** Please print using a ballpoint pen. Complete this page in full, sign your name and date. Mail to GEHA in the enclosed postage-paid envelope and include your: 1) initial premium payment and 2) completed Bank Draft Authorization form (if applicable). Please see the premium rate schedule to determine your correct premium payment. All fields are required. Incomplete information may delay processing and your effective date of coverage.

**MEMBER OR SURVIVOR ANNUITANT INFORMATION**

- **GEHA ID CARD NUMBER OR SOCIAL SECURITY NUMBER OF FEDERAL EMPLOYEE**

- **First Name**

- **Middle Initial**

- **Last Name**

- **Physical Address**

- **City**

- **State**

- **ZIP**

- **Daytime Phone**

- **Birth Date MM/DD/YY**

- **Married**

- **YES**

- **NO**

- **MALE**

- **FEMALE**

- **Mailing Address If Different Than Physical Address**

- **Name of Federal Agency Employed/Retired/Formerly Employed by**

- **ACTIVE**

- **RETIRED**

- **FORMER**

- **SURVIVOR ANNUITANT Put Your Social Security Number Here**

**SELECT COVERAGE OPTION**

- **Self Only**

- **Self and One Dependent**

- **Self and Family**

**DEPENDENT COVERAGE INFORMATION** (Relationship Codes: 1=spouse 2=natural child 3=other, specify)

<table>
<thead>
<tr>
<th>RELATIONSHIP CODE</th>
<th>FIRST NAME</th>
<th>MIDDLE Initial</th>
<th>LAST NAME (IF DIFFERENT)</th>
<th>GENDER M/F</th>
<th>DATE OF BIRTH MM/DD/YY</th>
<th>ZIP CODE (IF DIFFERENT)</th>
<th>SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SELECT ONE PAYMENT OPTION** (Please enclose initial premium payment)

- **Bank Draft from Checking Account**

- **Bank Draft from Savings Account**

- **Billing from GEHA**

  - **Quarterly**
  - **Semi-Annually**
  - **Annually**

**OTHER COVERAGE INFORMATION**

- **My Federal Employees Health Benefits Plan is/will be**

- **Enrollment Code**

- **Do you, your spouse or any other eligible dependent(s) have medical or dental coverage, other than the FEHB plan listed above?**

  - **YES**
  - **NO**

- **If yes, list name of insurance**

- **Effective date of policy**

- **Insurance phone #**

- **Policy holder**

- **Covered family members**

I have read and understand the information on the reverse side of this form. I hereby apply for coverage for myself and my eligible dependent(s), if any. The information provided above is true and correct to the best of my knowledge.

**Signature:**

**Date:**

Please allow us 3 to 4 weeks to process your application and mail your ID cards.
IMPORTANT INFORMATION

- You must be a current or former federal employee or annuitant who is (or was) eligible for Federal Employees Health Benefits. Eligible dependents are your legally married spouse and each unmarried child who is under age 26.

- Connection Dental Plus benefits are neither offered nor guaranteed by OPM under the contract with the FEHB or FEDVIP programs.

- Eligible dependents can be enrolled only if the current or former federal employee or annuitant enrolls.

- Your coverage will be effective on the first day of the month following receipt of your completed application and initial premium payment.

- You must notify Connection Dental Plus of any enrollment changes. Your payroll office will not notify Connection Dental Plus for you.

- You must remit premiums within 31 days of the due date or your coverage will automatically lapse.

- Please read the Connection Dental Plus Benefit Plan brochure carefully. Deductibles, waiting periods and maximum limits do apply.

- Benefits are subject to plan provisions, limitations and exclusions.

- Only dentists participating in the Connection Dental network are bound by the Connection Dental fee schedule.

- Connection Dental Plus is a supplemental dental plan and will pay last after any other coverage. When you have other coverage, submit your claim to the primary plan(s). Then submit to Connection Dental Plus your claim along with the other coverage Explanation of Benefits showing payment or denial.

Information available from the GEHA website, 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.

Connection Dental Plus Pricing – Sign in to your online account to look up pricing information for common dental procedures in your area.
BANK DRAFT AUTHORIZATION FORM

This form is required for monthly or quarterly Bank Draft. Bank Draft is available from a checking or savings account. We will contact your bank to set up the automatic draft for future payments.

INSTRUCTIONS: Please print with ballpoint pen or type. Complete this page in full, sign your name and date. Attach a blank check marked VOID in the space below. Mail to GEHA in the enclosed postage-paid envelope.

New plan enrollees: Please enclose a check or money order for your first premium payment, along with your Enrollment Application. Make your checks payable to: GEHA Connection Dental Plus.

MEMBER OR SURVIVOR ANNUITANT INFORMATION

GEHA ID CARD NUMBER OR SOCIAL SECURITY NUMBER OF FEDERAL EMPLOYEE

First Name                      Middle Initial                      Last Name                      Daytime Phone

SURVIVOR ANNUITANT, PUT YOUR OWN SOCIAL SECURITY NUMBER HERE

BANK INFORMATION

Bank Name                      Street Address

City                          State                          ZIP                         Daytime Phone

Select One Payment Option:

☐ Bank Draft from Checking Account
   ☐ Monthly  ☐ Quarterly

☐ Bank Draft from Savings Account
   ☐ Monthly  ☐ Quarterly

ATTACH BLANK VOIDED CHECK
or
SAVINGS ACCOUNT DEPOSIT SLIP HERE

Verify with your banking institution the correct account number and routing number when using savings account option.

I authorize my bank listed above to pay and charge my bank account for checks drawn by and payable to the order of GEHA Connection Dental Plus on a monthly or quarterly basis as indicated above. I understand that I will be charged in advance of the coverage month by automatic withdrawal. This authorization shall extend to any premium increase affected by the Connection Dental Plus plan under the terms thereof.

Signature: ____________________________ Date: ____________________________
Open to *all* current and former federal employees, *all* year long.

gehac.com/cdplus
(800) 793-9335
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)

Effective 01/01/14
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
Table of Contents.................................................. 2
Definitions ............................................................ 2
General Information ............................................. 3
General Provisions ................................................ 4
When Coverage Begins ........................................ 5
When Coverage Terminates ................................. 5
Rights of a Covered Person .................................. 7
HIPAA Notice of Privacy Practices...................... 8
Privacy of Health Information ............................ 12
Continuation of Coverage........................................ 14
USERRA Coverage ............................................. 16
Other Dental Coverage .......................................... 18
Benefit Provisions............................................... 19
Covered Services ............................................... 22
Services Not Covered .......................................... 24
Covered Services List ......................................... 25
Claim Provisions............................................... 27
Connection Programs – Value Added Benefit .... 31
Benefit Schedule............................................... 32

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 denturist 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 26, 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.
- 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.

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.
**Continuation of Dependent Child Coverage After Age 26**

Subject to the other terms and conditions stated herein, coverage for any unmarried Dependent Child whose coverage is terminating because he has reached age 26 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 26; 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 he or she loses 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 Dental Plan on the rules governing your COBRA Continuation of Coverage rights.

Esta Descripción Sumaria Del Plan contiene un resumen en Inglés de sus derechos y ventajas del 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 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 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;
- Follow the terms of the notice that is currently in effect; and
- Notify affected individuals following a breach of unsecured protected health information as provided in the HIPAA regulations.

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 and/or the Connection Dental Federal program, the plans will share protected health information with each other as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement. For example, enrollment information regarding address changes and payment information in order to coordinate benefits are some of the ways in which information may be shared.

If you are not a member of GEHA through the Federal Health Benefits program and/or the Connection Dental Federal 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...
includes 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 them as your personal representative. In addition, in the event of your death, an executor, administrator, or other person authorized under the law to act on behalf of you or your estate will be treated as your personal representative.

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.

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 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 a 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.

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 described in this notice will be made only with your written authorization. These include:

- Uses and disclosures for marketing purposes; and
- Uses and disclosures that constitute the sale of PHI.

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. If GEHA agrees to a restriction, we may also terminate our agreement to the 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 at alternative locations if you agree to receive your communications in that manner.

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 “designated record set” contains medical and payment records and any other records that GEHA uses for making decisions about you. You may request an electronic copy of the protected health information and GEHA will provide in the electronic form and format requested if it is readily producible in that form and format, or, if not, will provide in a readable electronic form and format as agreed to by you and GEHA. You may direct GEHA to send the protected health information directly to another person by clearly identifying the designated person and where to send the information. 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 GEHA is unable to meet the 30 days, we may extend the time for up to an additional 30 days by providing a written statement of the reasons for the delay within the initial 30 days and the date by which the request will be completed. 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 www.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.

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;

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.
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 permitted uses or disclosures 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);
• 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 Internal operations;
• Enrollment;
• Claims;
• Call Center;
• Quality Assurance;
• Cost Recovery;
• Legal;
• Data Analysis;
• Information Services;
• PPOs;
• Connection Dental;
• Provider Records;
• Accounting;
• Marketing;
• Appeals and Grievances;
• Internal Audits;
• Connection Programs;
• Enterprise Security & Risk Management; 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.
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 may 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 may 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 of Coverage must pay for that 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 a Member reduces or eliminates coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for the Eligible Dependent spouse even though his or her coverage was reduced or eliminated before the divorce or separation;
- An Eligible Dependent Child ceasing to qualify as an Eligible 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.

Maximum Period of Continuation Coverage
If a qualified beneficiary elects COBRA Continuation of Coverage, coverage may be continued for up to thirty-six (36) months, measured from the date of the Qualifying Event.
**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.

**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 a qualified beneficiary fails to make the required Premium payment to continue coverage.
- The date the qualified beneficiary becomes entitled to Medicare (this applies only to a qualified beneficiary who becomes eligible for Medicare after electing COBRA continuation coverage).
- 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.

**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.
The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") provides protections to certain employees who go on leave to provide Service in the Uniformed Services. For instance, those employees are entitled to rights under USERRA to continue coverage for themselves and their Dependents 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.

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 Member’s 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.

Voluntary Termination of Coverage while on USERRA Leave

If a Member goes on USERRA leave, and voluntarily terminates his or her coverage while on such leave, the Member will not be treated as having voluntarily terminated coverage under any other provision of The Dental Plan, so long as the Member timely returns to work, as described below. Therefore, the Member may re-enroll immediately in The Dental Plan without having to satisfy a minimum Waiting Period. Additionally, any Dental Plan Waiting Period for the Member or the Member’s Dependents will not start over, but will instead resume as of the date the Member re-enrolls himself and his Dependents in Coverage under The Dental Plan.

Duration of Coverage

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 Service in the Uniformed Services by either reporting to work (when absent for less than 31 days) or applying for reemployment (if absent for more than 30 days). The time for returning to work depends on the length of the absence, as follows:
## USERRA Coverage continued

<table>
<thead>
<tr>
<th>Period of Absence</th>
<th>Return to Work Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 31 days</td>
<td>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.</td>
</tr>
<tr>
<td>More than 30 days but less than 181 days</td>
<td>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.</td>
</tr>
<tr>
<td>More than 180 days</td>
<td>Submit an application for employment not later than 90 days after the completion of the service.</td>
</tr>
<tr>
<td>Any period, if the absence was for purposes of an examination for fitness to perform service.</td>
<td>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.</td>
</tr>
<tr>
<td>Any period, if you were hospitalized for or are convalescing from an Injury or Illness incurred or aggravated as a result of your service.</td>
<td>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.</td>
</tr>
</tbody>
</table>
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.

Other Dental Coverage
“Other Dental Coverage” means any dental plan, contract or other means of paying the cost of dental care, including but not limited to:
- Group or blanket coverage; including Dental Maintenance Organizations
- Any hospital, medical or dental service plan for prepaid group coverage;
- Labor-management trusted plans, union welfare plans, employer organization plans, employee benefit organization plans and professional association plans;
- Any other employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended;
- Government programs, including compulsory no-fault automobile coverage and Medicare, unless coordinating benefits with these types of programs is prohibited by law;
- Plans in the Federal Employees Health Benefits Program (FEHBP); and
- 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 of coverage. Such termination will be considered Voluntary Termination.

Right of Recovery
We have the right to retrieve any overpayments. These are amounts that have been paid in excess of that called for by these or any other provisions. Such recovery may be from the Covered Person for whom the payments were made. It may 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.
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 our network of providers. 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 our network and agrees to limit charges to a Maximum Charge as determined by the network. If you use a Participating Provider, you may pay a lower Coinsurance than if you used a Non-participating Provider.

Our network of Participating Providers is subject to change. It is your responsibility to verify with the Participating Provider that the provider currently participates before you receive care.

GEHA does not guarantee that Participating Providers are available for all specialties, are available in all areas or that the 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.
- Recement 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 (e.g., fixed bridge restoration, removable partial or complete denture, etc.) will be considered a Covered Service only when it replaces a functioning natural tooth extracted after the Effective Date of Coverage.
- The replacement of an existing prosthodontic device will be considered a Covered Service only if at least one of the following conditions is met:
  - The replacement appliance is required because at least one natural tooth was necessarily extracted after the date the person became a Covered Person and the existing appliance could not have been made serviceable. If the existing appliance could have been made serviceable, benefits will be payable only for the expense for that portion of the replacement appliance that replaces the natural teeth extracted after the date the person became a Covered Person.
  - The replacement appliance replaces an existing appliance that is at least five years old and cannot be made serviceable.
  - The replacement appliance is required as the result of Accidental Bodily Injury that occurs after the date the person became a Covered Person.
- Denture rebase, reline, or tissue conditioning – a maximum of once in any 12 consecutive month period and only 12 months after initial insertion.
- Recement fixed partial denture – limited to one per Calendar Year, after 12 months have passed since initial placement.
- Replacement of all teeth and acrylic on cast metal frame – limited to once every five years.
- General Anesthesia – limited to complex covered oral surgery.

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
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 (e.g., fixed bridge restoration, removable partial or complete denture, etc.) when it replaces natural teeth extracted or missing, including due to congenital defects, prior to the Effective Date of Coverage.

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.


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. These services or treatment 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 Calendar Year in which the expense was incurred, except when the Member was legally incapable.
 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—Established Patient
- D0140 Limited Oral Evaluation—Problem Focused
- D0145 Oral Evaluation for a Patient Under 3 Years of Age and Counseling with Primary Caregiver
- D0150 Comprehensive Oral Evaluation—New or Established Patient
- D0180 Comprehensive Periodontal Evaluation—New or Established Patient
- D0270 Bitewing-Single Radiographic Image
- D0272 Bitewings-2 Radiographic Images
- D0273 Bitewings-3 Radiographic Images
- D0274 Bitewings-4 Radiographic Images
- D0277 Vertical Bitewings-7 to 8 Radiographic Images

#### Preventive
- D1110 Prophylaxis Adult
- D1120 Prophylaxis Child
- *D1206 Topical Application of Fluoride Varnish
- *D1208 Topical Application of Fluoride

#### Class B - $50 Calendar Year Deductible

##### Per Person, No Waiting Period

#### Diagnostic
- D0210 Intraoral-Complete Series of Radiographic Images
- D0220 Intraoral-Periapical-First Radiographic Image
- D0230 Intraoral-Periapical-each additional Radiographic Image
- D0330 Panoramic Radiographic Image

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

#### Restorative
- D1352 Preventive Resin Restoration in a Moderate-High Caries Risk Patient—Permanent Tooth
- D2140 Amalgam-1 Surface, Primary or Permanent
- D2150 Amalgam-2 Surfaces, Primary or Permanent
- D2160 Amalgam-3 Surfaces, Primary or Permanent
- D2161 Amalgam-4 or More Surfaces, Primary or Permanent
- D2330 Resin-Based Composite 1 Surface, Anterior
- D2331 Resin-Based Composite 2 Surfaces, Anterior
- D2332 Resin-Based Composite 3 Surfaces, Anterior
- D2335 Resin-Based Composite 4 or More Surfaces or Involving Incisal Angle, (Anterior)
- *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
- *D2395 Prefabricated Porcelain/Ceramic Crown—Primary Tooth
- D2930 Prefabricated Stainless Steel Crown—Primary Tooth
- D2934 Prefabricated Esthetic Coated Stainless Steel Crown—Primary Tooth
- D2951 Pin Retention-Per Tooth, in Addition to Restoration

#### Prosthodontics - Removable
- D5410 Adjust Complete Denture-Maxillary
- D5411 Adjust Complete Denture-Mandibular
- D5421 Adjust Partial Denture-Maxillary
- D5422 Adjust Partial Denture-Mandibular

#### Oral Surgery
- D7110 Extraction, Coronal Remnants-Deciduous Tooth
- D7140 Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)
- D7210 Surgical Removal of Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth, and Including Elevation of Mucoperiosteal Flap if Indicated
- D7250 Surgical Removal of Residual Tooth Roots-(Cutting)
- D7310 Alveolectomy in Conjunction with Extractions-4 or More Teeth or Tooth Spaces, Per Quad
- D7311 Alveolectomy in Conjunction with Extractions 1 to 3 Teeth or Tooth Spaces, Per Quad
- D7320 Alveolectomy Not in Conjunction with Extractions-4 or More Teeth or Tooth Spaces, Per Quad
- D7321 Alveolectomy not in Conjunction with Extractions-1 to 3 Teeth or Tooth Space, Per Quad
- D7450 Removal of Benign Odontogenic Cyst or Tumor-Lesion Diameter Up to 1.25cm
- D7510 Incision and Drainage of Abscess-Intraoral Soft Tissue
- D7511 Incision and Drainage of Abscess-Intraoral Soft Tissue Complicated (includes drainage of multiple fascial spaces)
- D7960 Frenulectomy-Also Known as Frenectomy or Frenotomy-
- D7963 Frenuloplasty
- D7970 Excision of Hyperplastic Tissue-Per Arch
- D7971 Excision of Pericoronal Gingiva

#### Miscellaneous
- D9110 Palliative (ER) Treatment of Dental Pain-minor procedure
- D9910 Application of Desensitizing Medicament

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

#### Restorative
- D2390 Resin-Based Composite Crown, Anterior
- *D2520 Inlay-Metallic-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
- *D2630 Inlay—Porcelain/Ceramic—3 or More Surfaces
- *D2643 Onlay—Porcelain/Ceramic—3 or More Surfaces
- *D2644 Onlay—Porcelain/Ceramic—4 or More Surfaces
- *D2710 Crown-Resin-Based Composite (Indirect)
- *D2712 Crown-¾ Resin-Based Composite (Indirect)
- *D2720 Crown-Resin with High Noble Metal
- *D2721 Crown-Resin with Predominantly Base Metal
- *D2722 Crown-Resin with Noble Metal
### Covered Services List continued

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2740</td>
<td>Crown-Porcelain/Ceramic Substrate</td>
</tr>
<tr>
<td>D2750</td>
<td>Crown-Porcelain Fused to High Noble Metal</td>
</tr>
<tr>
<td>D2751</td>
<td>Crown-Porcelain Fused to Predominantly Base Metal</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown-Porcelain Fused to Noble Metal</td>
</tr>
<tr>
<td>D2753</td>
<td>Crown-Porcelain Fused to Predominantly Base Metal</td>
</tr>
<tr>
<td>D2790</td>
<td>Crown-Porcelain Fused to Noble Metal</td>
</tr>
<tr>
<td>D2791</td>
<td>Crown-Porcelain Fused to Predominantly Base Metal</td>
</tr>
<tr>
<td>D2792</td>
<td>Crown-Porcelain Fused to Noble Metal</td>
</tr>
<tr>
<td>D2910</td>
<td>Recement Inlay, Onlay, or Partial Coverage Restoration</td>
</tr>
<tr>
<td>D2915</td>
<td>Recement Cast or Prefabricated Post and Core</td>
</tr>
<tr>
<td>D2920</td>
<td>Recement Crown</td>
</tr>
<tr>
<td>D2940</td>
<td>Protective Restoration</td>
</tr>
<tr>
<td>D2950</td>
<td>Core Buildup, Including Any Pins When Required</td>
</tr>
<tr>
<td>D2952</td>
<td>Post and Core In Addition to Crown - Indirectly Fabricated</td>
</tr>
<tr>
<td>D2953</td>
<td>Each Additional Indirectly Fabricated Post–Same Tooth</td>
</tr>
<tr>
<td>D2954</td>
<td>Prefabricated Post and Core In Addition to Crown</td>
</tr>
<tr>
<td>D2957</td>
<td>Each Additional Prefabricated Post–Same Tooth</td>
</tr>
</tbody>
</table>

### Endodontics

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3110</td>
<td>Pulp Cap-Direct (Excluding Final Restoration)</td>
</tr>
<tr>
<td>D3220</td>
<td>Therapeutic Pulpotomy (Excluding Final Restoration)</td>
</tr>
<tr>
<td>D3221</td>
<td>Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament</td>
</tr>
<tr>
<td>D3222</td>
<td>Partial pulpotomy For Apexogenesis–Permanent Tooth with Incomplete Root Development</td>
</tr>
<tr>
<td>D3310</td>
<td>Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)</td>
</tr>
<tr>
<td>D3320</td>
<td>Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)</td>
</tr>
<tr>
<td>D3330</td>
<td>Endodontic Therapy, Molar (Excluding Final Restoration)</td>
</tr>
<tr>
<td>D3346</td>
<td>Retreatment of Previous Root Canal Therapy–Anterior</td>
</tr>
<tr>
<td>D3347</td>
<td>Retreatment of Previous Root Canal Therapy–Bicuspid</td>
</tr>
<tr>
<td>D3348</td>
<td>Retreatment of Previous Root Canal Therapy–Molar</td>
</tr>
</tbody>
</table>

### Class C continued

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3340</td>
<td>Apicoectomy</td>
</tr>
<tr>
<td>D3421</td>
<td>Apicoectomy, Bicuspid (First Root)</td>
</tr>
<tr>
<td>D3425</td>
<td>Apicoectomy, Molar (First Root)</td>
</tr>
<tr>
<td>D3426</td>
<td>Apicoectomy, Each Additional Root</td>
</tr>
<tr>
<td>D3430</td>
<td>Tooth in the Same Surgical Site</td>
</tr>
</tbody>
</table>

### Periodontics

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>Gingivectomy or Gingivoplasty-4 Or More Contiguous Teeth or Tooth Bounded Spaces, Per Quad</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or Gingivoplasty-1 to 3 Contiguous Teeth, Or Tooth Bounded Spaces Per Quad</td>
</tr>
<tr>
<td>D4240</td>
<td>Gingival Flap Procedure, Including Root Planing-4 or More Contiguous Teeth or Tooth Bounded Spaces Per Quad</td>
</tr>
<tr>
<td>D4241</td>
<td>Gingival Flap Procedure, Including Root Planing-1 to 3 Contiguous Teeth or Tooth Bounded Spaces Per Quad</td>
</tr>
<tr>
<td>D4249</td>
<td>Clinical Crown Lengthening-Hard Tissue</td>
</tr>
</tbody>
</table>

## Endodontics continued

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4260</td>
<td>Osseous Surgery (Including Flap Entry and Closure)-4 or More Contiguous Teeth or Tooth Bounded Spaces Per Quad</td>
</tr>
<tr>
<td>D4261</td>
<td>Osseous Surgery (Including Flap Entry and Closure)-1 to 3 Contiguous Teeth or Tooth Bounded Spaces Per Quad</td>
</tr>
<tr>
<td>D4263</td>
<td>Bone Replacement Graft–First Site in Quad</td>
</tr>
<tr>
<td>D4264</td>
<td>Bone Replacement Graft–Each Additional Site in Quad</td>
</tr>
<tr>
<td>D4266</td>
<td>Guided Tissue Regeneration–Resorbable Barrier, Per Site</td>
</tr>
<tr>
<td>D4267</td>
<td>Guided Tissue Regeneration–Nonresorbable Barrier Per Site (Including Membrane Removal)</td>
</tr>
<tr>
<td>D4270</td>
<td>Pedicle Soft Tissue Graft Procedure</td>
</tr>
<tr>
<td>D4273</td>
<td>Subepithelial Connective Tissue Graft Procedures, Per Tooth</td>
</tr>
<tr>
<td>D4275</td>
<td>Soft Tissue Allograft</td>
</tr>
<tr>
<td>D4276</td>
<td>Combined Connective Tissue and Double Pedicle Graft, Per Tooth</td>
</tr>
<tr>
<td>D4277</td>
<td>Free Soft Tissue Graft Procedure (Including Donor Site Surgery)</td>
</tr>
<tr>
<td>D4278</td>
<td>Each Additional Contiguous Tooth or Edentulous Tooth Position in Same Graft Site</td>
</tr>
<tr>
<td>D4341</td>
<td>Periocular Wheel and Root Planing-4 or More Teeth Per Quad</td>
</tr>
<tr>
<td>D4342</td>
<td>Periodontal Scaling and Root Planing-1 to 3 Teeth, Per Quad</td>
</tr>
</tbody>
</table>

### Prosthodontics - Removable

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>Complete Denture-Maxillary</td>
</tr>
<tr>
<td>D5120</td>
<td>Complete Denture-Mandibular</td>
</tr>
<tr>
<td>D5130</td>
<td>Immediate Denture-Maxillary</td>
</tr>
<tr>
<td>D5140</td>
<td>Immediate Denture-Mandibular</td>
</tr>
<tr>
<td>D5211</td>
<td>Maxillary Partial Denture-Resin Base (Including Any Conventional Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5212</td>
<td>Mandibular Partial Denture-Resin Base (Including Any Conventional Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5213</td>
<td>Mandibular Partial Denture-Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5214</td>
<td>Mandibular Partial Denture-Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5225</td>
<td>Maxillary Partial Denture-Flexible Base (Including Any Clasps, Rests and Teeth)</td>
</tr>
<tr>
<td>D5226</td>
<td>Mandibular Partial Denture-Flexible Base (Including Any Clasp, Rests and Teeth)</td>
</tr>
<tr>
<td>D5281</td>
<td>Removeable Unilateral Partial Denture -1 Piece Cast Metal (Including Clasps, and Teeth)</td>
</tr>
<tr>
<td>D5510</td>
<td>Repair Broken Complete Denture Base</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace Missing or Broken Teeth-Complete Denture (Each Tooth)</td>
</tr>
<tr>
<td>D5610</td>
<td>Repair Resin Denture Base</td>
</tr>
<tr>
<td>D5620</td>
<td>Repair Cast Framework</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or Replace Broken Clasp</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace Broken Teeth-Per Tooth</td>
</tr>
<tr>
<td>D5650</td>
<td>Add Tooth to Existing Partial Denture</td>
</tr>
<tr>
<td>D5660</td>
<td>Add Clasp to Existing Partial Denture</td>
</tr>
<tr>
<td>D5670</td>
<td>Replace All Teeth and Acrylic on Cast Metal Framework, Maxillary</td>
</tr>
<tr>
<td>D5671</td>
<td>Replace All Teeth and Acrylic on Cast Metal Framework, Mandibular</td>
</tr>
<tr>
<td>D5710</td>
<td>Rebase Complete Maxillary Denture</td>
</tr>
</tbody>
</table>
## Covered Services List continued

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5711</td>
<td>Rebase Complete Mandibular Denture</td>
</tr>
<tr>
<td>D5720</td>
<td>Rebase Maxillary Partial Denture</td>
</tr>
<tr>
<td>D5721</td>
<td>Rebase Mandibular Partial Denture</td>
</tr>
<tr>
<td>D5730</td>
<td>Reline Complete Maxillary Denture (Chairside)</td>
</tr>
<tr>
<td>D5731</td>
<td>Reline Complete Mandibular Denture (Chairside)</td>
</tr>
<tr>
<td>D5740</td>
<td>Reline Maxillary Partial Denture (Chairside)</td>
</tr>
<tr>
<td>D5741</td>
<td>Reline Mandibular Partial Denture (Chairside)</td>
</tr>
<tr>
<td>D5750</td>
<td>Reline Complete Maxillary Denture (Laboratory)</td>
</tr>
<tr>
<td>D5751</td>
<td>Reline Complete Mandibular Denture (Laboratory)</td>
</tr>
<tr>
<td>D5760</td>
<td>Reline Maxillary Partial Denture (Laboratory)</td>
</tr>
<tr>
<td>D5761</td>
<td>Reline Mandibular Partial Denture (Laboratory)</td>
</tr>
<tr>
<td>D5850</td>
<td>Tissue Conditioning, Maxillary</td>
</tr>
<tr>
<td>D5851</td>
<td>Tissue Conditioning, Mandibular</td>
</tr>
<tr>
<td><strong>Prosthodontics - Fixed</strong></td>
<td></td>
</tr>
<tr>
<td>D6205</td>
<td>Pontic-Indirect Resin Based Composite</td>
</tr>
<tr>
<td>*D6210</td>
<td>Pontic-Cast High Noble Metal</td>
</tr>
<tr>
<td>D6211</td>
<td>Pontic-Cast Predominantly Base Metal</td>
</tr>
<tr>
<td>*D6212</td>
<td>Pontic-Cast Noble Metal</td>
</tr>
<tr>
<td>*D6240</td>
<td>Pontic-Porcelain Fused to High Noble Metal</td>
</tr>
<tr>
<td>D6241</td>
<td>Pontic-Porcelain Fused to Predominantly Base Metal</td>
</tr>
<tr>
<td>*D6242</td>
<td>Pontic-Porcelain Fused to Noble Metal</td>
</tr>
<tr>
<td>*D6245</td>
<td>Pontic-Porcelain/Ceramic</td>
</tr>
<tr>
<td>*D6250</td>
<td>Pontic-Resin with High Noble Metal</td>
</tr>
<tr>
<td>D6251</td>
<td>Pontic-Resin with Predominantly Base Metal</td>
</tr>
<tr>
<td>*D6252</td>
<td>Pontic-Resin with Noble Metal</td>
</tr>
<tr>
<td>D6600</td>
<td>Inlay-Porcelain/Ceramic, 2 Surfaces</td>
</tr>
<tr>
<td>D6601</td>
<td>Inlay-Porcelain/Ceramic, 3 or More Surfaces</td>
</tr>
<tr>
<td>*D6602</td>
<td>Inlay-Cast High Noble Metal, 2 Surfaces</td>
</tr>
<tr>
<td>*D6603</td>
<td>Inlay-Cast High Noble Metal, 3 or More Surfaces</td>
</tr>
<tr>
<td>D6604</td>
<td>Inlay-Cast Predominantly Base Metal, 2 Surfaces</td>
</tr>
<tr>
<td>D6605</td>
<td>Inlay-Cast Predominantly Base Metal, 3 or More Surfaces</td>
</tr>
<tr>
<td>*D6606</td>
<td>Inlay-Cast Noble Metal, 2 Surfaces</td>
</tr>
<tr>
<td>*D6607</td>
<td>Inlay-Cast Noble Metal, 3 or More Surfaces</td>
</tr>
<tr>
<td>D6608</td>
<td>Onlay-Porcelain/Ceramic, 2 Surfaces</td>
</tr>
<tr>
<td>D6609</td>
<td>Onlay-Porcelain/Ceramic, 3 or More Surfaces</td>
</tr>
<tr>
<td>*D6610</td>
<td>Onlay-Cast High Noble Metal, 2 Surfaces</td>
</tr>
<tr>
<td>*D6611</td>
<td>Onlay-Cast High Noble Metal, 3 or More Surfaces</td>
</tr>
<tr>
<td>D6612</td>
<td>Onlay-Cast Predominantly Base Metal, 2 Surfaces</td>
</tr>
<tr>
<td>D6613</td>
<td>Onlay-Cast Predominantly Base Metal, 3 or More Surfaces</td>
</tr>
<tr>
<td>*D6614</td>
<td>Onlay-Cast Noble Metal, 2 Surfaces</td>
</tr>
<tr>
<td>*D6615</td>
<td>Onlay-Cast Noble Metal, 3 or More Surfaces</td>
</tr>
<tr>
<td>D6710</td>
<td>Crown-Indirect Resin Based Composite</td>
</tr>
<tr>
<td>*D6720</td>
<td>Crown-Resin with High Noble Metal</td>
</tr>
<tr>
<td>D6721</td>
<td>Crown-Resin with Predominantly Base Metal</td>
</tr>
<tr>
<td>*D6722</td>
<td>Crown-Resin with Noble Metal</td>
</tr>
<tr>
<td>*D6740</td>
<td>Crown-Porcelain/Ceramic</td>
</tr>
<tr>
<td>*D6750</td>
<td>Crown-Porcelain Fused to High Noble Metal</td>
</tr>
<tr>
<td>D6751</td>
<td>Crown-Porcelain Fused to Predominantly Base Metal</td>
</tr>
<tr>
<td>*D6752</td>
<td>Crown-Porcelain Fused to Noble Metal</td>
</tr>
<tr>
<td>*D6780</td>
<td>Crown-¾ Cast High Noble Metal</td>
</tr>
<tr>
<td>D6781</td>
<td>Crown-¾ Cast Predominantly Base Metal</td>
</tr>
<tr>
<td>*D6782</td>
<td>Crown-¾ Cast Noble Metal</td>
</tr>
<tr>
<td>*D6783</td>
<td>Crown-¾ Porcelain/Ceramic</td>
</tr>
<tr>
<td>*D6790</td>
<td>Crown-Full Cast High Noble Metal</td>
</tr>
<tr>
<td>D6791</td>
<td>Crown-Full Cast Predominantly Base Metal</td>
</tr>
<tr>
<td>*D6792</td>
<td>Crown-Full Cast Noble Metal</td>
</tr>
<tr>
<td>D6930</td>
<td>Recement Fixed Partial Denture</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td></td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of Impacted Tooth Soft Tissue</td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of Impacted Tooth Partially Bony</td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of Impacted Tooth Complete Bony</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td></td>
</tr>
<tr>
<td>D9220</td>
<td>Deep Sedation/General Anesthesia-First 30 Min.</td>
</tr>
<tr>
<td>D9221</td>
<td>Deep Sedation/General Anesthesia-Each Add 15 Min.</td>
</tr>
<tr>
<td><strong>Class D - No Deductible, 24-Month Waiting Period,</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Limited To Covered Child</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td></td>
</tr>
<tr>
<td>D8070</td>
<td>Comprehensive Ortho Treatment of the Transitional Dentition</td>
</tr>
<tr>
<td>D8080</td>
<td>Comprehensive Ortho Treatment of the Adolescent Dentition</td>
</tr>
</tbody>
</table>

## 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
Claim Provisions continued

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

Notification of Claim Decision
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 Dental Plan; or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the above name and address. The postmark on 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 in connection with the initial benefit decision.

If the denial was based, in whole or in part, on any medical judgment, we will consult with a health care professional having appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will be different from any individual consulted in connection with the original claim decision, and will not be a subordinate of any such individual. If The Dental Plan obtained advice from any medical experts in making a decision on 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 decision, 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. 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 upon 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 Dental Plan; or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the above name and address. The postmark on 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 in connection with a prior benefits decision.

If the denial was based, in whole or in part, on any medical judgment, we will consult with a health care professional having appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will be different from any individual consulted in connection with the original claim decision, and will not be a subordinate of any such individual. If The Dental Plan obtained advice from any medical experts in making a decision on 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 be subject to review only 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 may be brought to recover from The Dental Plan until the review procedure has been exhausted as described above.

Connection Programs – Value Added Benefit

For more information about Vision and Hearing benefits, visit our website at www.geha.com
# 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.

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

## 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.