

GEHA Connection Dental Plus
www.geha.com/CDPlus
800.793.9335

GEHA®

Plan Brochure

**A VOLUNTARY DENTAL ERISA 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.

ENROLLMENT OPTIONS FOR THIS DENTAL PLAN:

Self Only
Self and One Dependent
Self and Family
Dependent Only

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

Effective 07/01/2021

Using this Dental Brochure

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

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/CDPlus

File claims or predetermination of benefits to:

GEHA Connection Dental *Plus*

Attn: Claims Department

PO Box 21542

Eagan, MN 55121-9930

Information available from the GEHA website,
www.geha.com/CDPlus

Review claims online – You can look up Connection Dental *Plus* claim information online at www.geha.com/CDPlus where 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. www.geha.com/Find-Care

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. www.geha.com/Contact

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Definitions

Child

Child includes only:

- Your natural child, stepchild or a 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.

Covered Person

A Covered Person means a Member or Eligible Dependent who is covered under The Dental Plan.

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 a ge 26 (except as provided on page 6 of this brochure).

Eligible Person

An Eligible Person is:

- Any employee or annuitant of the Federal Government; or
- Any former federal employee or annuitant.

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 a Member.

FEDVIP

Federal Employees Dental and Vision Insurance 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, or any Eligible Person who elects to enroll any of his or her Eligible Dependents in the Dental Plan.

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.

You or Your

Means any Member.

General Information

Name of the Plan

The Dental Plan shall be known as GEHA Connection Dental *Plus*, which is part of the Government Employees Health Association, Inc. Voluntary Welfare Benefit Plan.

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*
PO Box 21542
Eagan, MN 55121-9930
(800) 793-9335

Agent for Service of Legal Process

CT Corporation System
120 South Central Avenue
Clayton, MO 63105

Plan Number 601

Plan Sponsor and its IRS Employer

Identification Number:

Government Employees Health Association, Inc.
PO Box 21542
Eagan, MN 55121-9930
EIN 44-0545275

Plan Effective Date January 1, 1997

Plan Renewal Date January 1

Plan Year End December 31

Named Fiduciary and Contact Information

Government Employees Health Association, Inc.
GEHA Connection Dental *Plus*
PO Box 21542
Eagan, MN 55121-9930
(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, semi-annual or annual 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.

Submit Premium payment to GEHA Connection Dental Plus, PO Box 952963, St. Louis, MO 63195-2963

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 first become an Eligible Person.

Your Eligible Dependents will be eligible for coverage on the date they first become Eligible Dependents.

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/or 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
- Submitting Your application and Premium payment or draft authorization to us.

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

Effective Date of Coverage

If all Enrollment Requirements are met, then You and/or Your Dependent(s)' coverage will be effective on the first day of the month next following the date We receive Your application and required Premium payment.

Coverage for any Eligible Dependents will become effective only on or after the date You become a Member. All Eligible Dependents enrolled more than 31 days after that date will have a separate Effective Date of Coverage and Waiting Periods as described under Covered Services.

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

An Eligible Person or Dependent shall become a Covered Person on the date coverage for such person begins.

When Coverage Terminates

Member

Your coverage will terminate on the earliest of the following dates:

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

- 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.

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 an Eligible Person's coverage is terminated, unless such Dependent is enrolled in Dependent Only coverage;

When Coverage Terminates *continued*

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 a 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
- In the case of an Eligible Person's Child, the last day of the month in which the Eligible Person's coverage terminates, unless such Dependent is enrolled in Dependent Only coverage.

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:

GEHA Connection Dental *Plus*
PO Box 21542
Eagan, MN 55121-9930

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.



Effective July 1, 2021
Government Employees Health Association, Inc

Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY

Purpose of this notice

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

State law

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

GEHA's designation as a HIPAA hybrid entity

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

GEHA's duties

We are required by law to:

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

How we may use or disclose your PHI

We typically use or share your health information in the following ways.

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

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

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

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

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

Notice of Privacy Practices *continued*

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

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

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

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

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

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

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

- With coroners, funeral directors, or medical examiners regarding decedents;
- To prevent or lessen a serious and imminent threat to the

health or safety of a person or the public if we believe that the use or disclosure is necessary under applicable federal and state laws;

- For special government functions where certain conditions apply, for Workers' Compensation, and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the law.

Disclosures to you or your personal representative

We must give you access to your own PHI, and will disclose it to you upon your request.

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

Authorization for other uses and disclosures

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

- Uses and disclosures for marketing purposes or research;
 - Uses and disclosures for the purposes of underwriting or fundraising, and
 - Uses and disclosures that constitute the sale of PHI.
- You may revoke an authorization at any time in writing, and we will stop using your PHI for that purpose once we receive your revocation. The revocation will not be effective for information we have already used or disclosed before you told us to stop.

Your rights

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

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

Notice of Privacy Practices *continued*

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

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

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

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

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

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

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

Revisions to the Notice

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

Contact

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

Privacy of Health Information

Definitions

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

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

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

- Determinations of eligibility or coverage, including coordination of benefits;
- Adjudication or subrogation of claims;
- Billing, claims management, collection activities;
- Review of health care services with respect to medical necessity or justification of charges;
- Utilization review activities, including predetermination of benefits; and
- Disclosures of Your name, address, date of birth, Social Security number, payment history, account number, and the name and address of the health plan to consumer reporting agencies for purposes of collection of Premium or reimbursement.

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

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

Disclosures to the Plan Sponsor

The Dental Plan may disclose PHI to GEHA for the following purposes:

- The Dental Plan may disclose summary health information to GEHA, for the purpose of making decisions regarding modifying, amending, or terminating The Dental Plan.
- The Dental Plan may disclose to GEHA information on whether You are participating in The Dental Plan, or have enrolled in or disenrolled from The Dental Plan.
- The Dental Plan may disclose PHI to GEHA to carry out plan administration functions that GEHA performs consistent with the provisions below.

Obligations of the Plan Sponsor

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

GEHA agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom GEHA provides PHI received from The Dental Plan agree to the same restrictions and conditions that apply to GEHA with respect to such PHI;

Privacy of Health Information *continued*

- Not use or disclose PHI for employment-related actions and decisions;
 - Not use or disclose PHI in connection with any other benefit or employee benefit plan of GEHA;
 - Report to The Dental Plan any PHI use or disclosure that is inconsistent with the 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, but not limited to, any employee whose job functions include the following:
- Mail and Internal operations;
 - Enrollment;
 - Claims;
 - Customer Care;
 - Quality Assurance;
 - Cost Recovery;
 - Legal;
 - Data Analysis;
 - Information Services;
 - PPOs;
 - Connection Dental;
 - Provider Records;
 - Accounting;
 - Marketing;
 - Appeals and Grievances;
 - Internal Audits;
 - Dental & Supplemental Products;
 - 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.

Continuation of Coverage

The right to COBRA Continuation of Coverage was created by a federal law and is called the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). COBRA continuation coverage 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:

GEHA Connection Dental *Plus* Administrator
PO Box 21542
Eagan, MN 55121-9930

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.

Continuation of Coverage *continued*

Notice Procedures

Warning: If Your notice is late or if You do not follow these notice procedures, all related qualified beneficiaries will lose the right to elect COBRA.

**Your notice must be mailed to:
GEHA Connection Dental *Plus*
PO Box 21542
Eagan, MN 55121-9930**

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

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

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.

USERRA Coverage

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 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

Coverage under USERRA may be continued for up to twenty-four (24) months. 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*

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

Other Dental Coverage

Coordination of Benefits

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

There is no change in benefit limits or maximums when We are the secondary payor. For example:

Primary Carrier(s) payment(s), GEHA is secondary or tertiary	In-Network
Billed Amount	\$165.00
GEHA's Allowable	\$139.00 (\$165-\$26 difference)
Primary Carrier's Payment	\$23.00
GEHA's Regular Benefit	\$111.20 (\$139 x 80%)
GEHA's Payment	\$111.20
Patient's Responsibility	\$4.80

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.

Primary Carrier(s) payment(s), GEHA is secondary or tertiary	Out-of-Network
Billed Amount	\$31.00
GEHA's Allowable	\$29.00 (\$31-\$2 difference)
Primary Carrier's Payment	\$8.00
GEHA's Regular Benefit	\$29.00 (\$29 x 100%)
GEHA's Payment	\$21.00
Patient's Responsibility	\$2.00

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.

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 plans as defined in the Employee Retirement Income Security Act of 1974, as amended;
- Government programs, including compulsory no-fault automobile coverage and Medicare, unless coordinating benefits with these types of programs is prohibited by law;
- Plans in the Federal Employees Health Benefits Program (FEHB); 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) User's Manual, *Current Dental Terminology*, shall be the reference for the selected procedure codes and description of Covered Services listed in the Covered Services List.

Benefit Percentage

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

Benefit Schedule

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

Calendar Year

The period of time that starts January 1 and ends December 31 of each year. For any Covered Person who first becomes covered after January 1 of any year, a Calendar Year shall be deemed to be the continuous period of time between the date coverage became effective and December 31 of that year.

Coinsurance

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

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

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

Benefit Provisions *continued*

Cosmetic Procedure

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

Covered Expense

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

Covered Service

A Covered Service is a service listed in the Covered Services List. A Covered Service must be incurred and completed while the person receiving the service is a Covered Person. Covered Services are subject to plan provisions for exclusions and limitations and meet acceptable standards of dental practice as determined by us. Services not listed in the Covered Services List are not Covered Services.

Deductible

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

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

Incur/Incurred

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

Maximum Benefit Limits

A single Calendar Year and lifetime Maximum Benefit applies to a Covered Person even if that Covered Person's coverage has been interrupted or if that Covered Person has been covered both as a Member and as a Dependent. Maximum Benefit Limits apply separately to each Covered Person. See Benefit Schedule.

Maximum Allowable Charge

Maximum Allowable Charge means the maximum amount allowed by The Dental Plan for Covered Services. The Maximum Allowable Charge is based on the general level of charges accepted by other providers in the area for like treatment, procedure or services. Our determination of what is allowable is final for the purpose of determining benefits payable under The Dental Plan.

Non-participating Provider

Non-participating Provider means a Dental Practitioner who does not participate in 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/Find-Care 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.
- Prefabricated stainless steel crowns – for Covered Persons under 18 years of age on primary teeth only. One per tooth every three Calendar Years.
- Prefabricated esthetic coated stainless steel crowns – for Covered Persons under age 18 years of age on anterior primary teeth only. One per tooth every three Calendar Years.
- Adjustment to denture and partial denture – two per Calendar Year, at least 6 months after delivery of appliance.

Class C

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

Class C Covered Services shall be limited as follows:

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

Covered Services *continued*

- Periodontal Maintenance— limited to two times per Calendar Year.
- Initial prosthodontic appliance (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, relines, 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.
- 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 two Calendar Years.

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:

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

Services Not Covered

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

1. Services or treatment for the provision of an initial prosthodontic appliance (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.
9. Congenital malformations.
10. Repair or replacement of orthodontic appliance.
11. Services or treatment provided primarily for Cosmetic Procedures.
12. Services or treatment provided by a member of Your immediate family or a member of the immediate family of Your spouse.
13. Any treatment not prescribed or performed by a licensed physician or Dental Practitioner.
14. Services or treatment for which no charge (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.
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, and restoration of tooth structure lost from attrition, erosion or abrasion, restorations for malalignment of teeth. This exclusion does not apply to Class D Covered Services.
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.
33. Any treatment related to mail order or online orthodontic services and supplies.

Covered Services List

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

Services listed with an asterisk (*) often have a choice of a lower cost treatment.

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—excluding Varnish

Class B - \$50 Calendar Year Deductible

Per Person, No Waiting Period

Diagnostic

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

Preventive

- D1351 Sealant-Per Tooth
- D1354 Interim Caries Arresting Medicament Application
- D1510 Space Maintainer-Fixed Unilateral
- D1516 Space Maintainer—Fixed Bilateral, Maxillary
- D1517 Space Maintainer—Fixed Bilateral, Mandibular
- D1520 Space Maintainer-Removable Unilateral
- D1526 Space Maintainer Removable Bilateral, Maxillary
- D1527 Space Maintainer Removable Bilateral, Mandibular
- D1575 Distal Shoe Space Maintainer—Fixed - Unilateral

Restorative

- D1352 Preventive Resin Restoration in a Moderate to High Caries Risk Patient—Permanent Tooth
- D2140 Amalgam-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
- *D2929 Prefabricated Porcelain/Ceramic Crown—Primary Tooth
- D2930 Prefabricated Stainless Steel Crown-Primary Tooth
- D2934 Prefabricated Esthetic Coated Stainless Steel Crown—Primary Tooth
- D2951 Pin Retention-Per Tooth, in Addition to Restoration

Prosthodontics – Removable

- D5410 Adjust Complete Denture-Maxillary
- D5411 Adjust Complete Denture-Mandibular
- D5421 Adjust Partial Denture- Maxillary
- D5422 Adjust Partial Denture- Mandibular

Oral Surgery

- D7111 Extraction, Coronal Remnants-Primary Tooth
- D7140 Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)
- D7210 Extraction, Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth, and Including Elevation of Mucoperiosteal Flap if Indicated
- D7220 Removal of Impacted Tooth - Soft Tissue
- D7230 Removal of Impacted Tooth - Partially Bony
- D7240 Removal of Impacted Tooth - Complete Bony
- D7250 Removal of Residual Tooth Roots-(Cutting)
- D7310 Alveoplasty in Conjunction with Extractions-4 or More Teeth or Tooth Spaces, Per Quadrant
- D7311 Alveoplasty in Conjunction with Extractions 1 to 3 Teeth or Tooth Spaces, Per Quadrant
- D7320 Alveoplasty Not in Conjunction with Extractions-4 or More Teeth or Tooth Spaces, Per Quadrant
- D7321 Alveoplasty 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 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 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
- *D2740 Crown-Porcelain/Ceramic
- *D2750 Crown-Porcelain Fused to High Noble Metal

Covered Services List *continued*

D2751 Crown-Porcelain Fused to Predominantly Base Metal	D4263 Bone Replacement Graft – Retained Natural Tooth - First Site in Quadrant
*D2752 Crown-Porcelain Fused to Noble Metal	D4264 Bone Replacement Graft - Retained Natural Tooth - Each Additional Site in Quadrant
D2781 Crown ¾ Cast Predominately Base Metal	D4266 Guided Tissue Regeneration - Resorbable Barrier, Per Site
*D2790 Crown-Full Cast High Noble Metal	D4267 Guided Tissue Regeneration – Non-resorbable Barrier, Per Site (Including Membrane Removal)
D2791 Crown-Full Cast Predominantly Base Metal	D4270 Pedicle Soft Tissue Graft Procedure
*D2792 Crown-Full Cast Noble Metal	D4273 Autogenous Connective Tissue Graft Procedure, (Including Donor and Recipient Surgical Sites) First Tooth, Implant or Edentulous Tooth Position in Graft
D2910 Re-cement or Re-bond Inlay, Onlay, Veneer or Partial Coverage Restoration	D4275 Non-Autogenous Connective Tissue Graft (Including Recipient Site and Donor Material) First Tooth, Implant, or Edentulous Tooth Position in Graft
D2915 Re-cement or Re-bond indirectly Fabricated or Prefabricated Post and Core	D4276 Combined Connective Tissue and Double Pedicle Graft, Per Tooth
D2920 Re-cement or Re-bond Crown	D4277 Free Soft Tissue Graft Procedure (Including Recipient and Donor Surgical Sites) First Tooth, Implant, or Edentulous Tooth Position in Graft
D2940 Protective Restoration	D4278 Free Soft Tissue Graft Procedure (Including Recipient and Donor Surgical Sites) Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site
D2950 Core Buildup, Including Any Pins When Required	D4283 Autogenous Connective Tissue Graft Procedure (Including Donor and Recipient Surgical Sites) – Each Additional Contiguous tooth, Implant or Edentulous Tooth Position in Same Graft Site
*D2952 Post and Core In Addition to Crown, Indirectly Fabricated	D4285 Non-Autogenous Connective Tissue Graft Procedure (Including Recipient Surgical Site and Donor Material) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site
*D2953 Each Additional Indirectly Fabricated Post – Same Tooth	D4341 Periodontal Scaling and Root Planing - 4 or More Teeth Per Quadrant
D2954 Prefabricated Post and Core in Addition to Crown	D4342 Periodontal Scaling and Root Planing - 1 to 3 Teeth, Per Quadrant
*D2957 Each Additional Prefabricated Post - Same Tooth	D4346 Scaling in Presence of Generalized Moderate or Severe Gingival Inflammation – Full Mouth, After Oral Evaluation
Endodontics	D4910 Periodontal Maintenance
D3110 Pulp Cap - Direct (Excluding Final Restoration)	Prosthodontics - Removable
D3220 Therapeutic Pulpotomy (Excluding Final Restoration) - Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament	D5110 Complete Denture - Maxillary
D3221 Pulpal Debridement, Primary and Permanent Teeth	D5120 Complete Denture - Mandibular
D3222 Partial pulpotomy For Apexogenesis – Permanent Tooth with Incomplete Root Development	D5130 Immediate Denture – Maxillary
D3310 Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	D5140 Immediate Denture - Mandibular
D3320 Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	D5211 Maxillary Partial Denture - Resin Base (Including, Retentive/Clasping Materials, Rests and Teeth)
D3330 Endodontic Therapy, Molar (Excluding Final Restoration)	D5212 Mandibular Partial Denture - Resin Base (Including, Retentive/Clasping Materials, Rests and Teeth)
D3346 Retreatment of Previous Root Canal Therapy - Anterior	D5213 Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)
D3347 Retreatment of Previous Root Canal Therapy - Premolar	D5214 Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)
D3348 Retreatment of Previous Root Canal Therapy - Molar	D5221 Immediate Maxillary Partial Denture – Resin Base (Including Any Conventional Clasps, Rests and Teeth)
D3410 Apicoectomy - Anterior	D5222 Immediate Mandibular Partial Denture – Resin Base (Including Any Conventional Clasps, Rests and Teeth)
D3421 Apicoectomy - Bicuspid (First Root)	
D3425 Apicoectomy - Molar (First Root)	
D3426 Apicoectomy (Each Additional Root)	
D3427 Periradicular Surgery without Apicoectomy	
D3428 Bone Graft in Conjunction with Periradicular Surgery	
D3429 Bone Graft in Conjunction with Periradicular Surgery – Each Additional Contiguous Tooth in the Same Surgical	
D3431 Biologic Materials to Aid in Soft & Osseous Tissue Regeneration in Conjunction with Periradicular Surgery	
D3432 Guided Tissue Regeneration, Resorbable Barrier, per site, in conjunction with Periradicular Surgery	
D3430 Tooth in the Same Surgical Site	
Periodontics	
D4210 Gingivectomy or Gingivoplasty - 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	

Covered Services List *continued*

D5223 Immediate Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)	*D6250 Pontic - Resin with High Noble Metal
D5224 Immediate Mandibular Partial Denture – Case Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)	D6251 Pontic - Resin with Predominantly Base Metal
D5225 Maxillary Partial Denture - Flexible Base (Including Any Clasps, Rests and Teeth)	*D6252 Pontic - Resin with Noble Metal
D5226 Mandibular Partial Denture - Flexible Base (Including Any Clasp, Rests and Teeth)	D6600 Retainer Inlay - Porcelain/Ceramic, 2 Surfaces
D5282 Removable Unilateral Partial Denture – 1 Piece Cast Metal (including clasps & teeth), Maxillary	D6601 Retainer Inlay - Porcelain/Ceramic, 3 or More Surfaces
D5283 Removable Unilateral Partial Denture – 1 Piece Cast Metal (including clasps & teeth), Mandibular	*D6602 Retainer Inlay - Cast High Noble Metal, 2 Surfaces
D5511 Repair Broken Complete Denture Base, Mandibular	*D6603 Retainer Inlay - Cast High Noble Metal, 3 or More Surfaces
D5512 Repair Broken Complete Denture Base, Maxillary	D6604 Retainer Inlay - Cast Predominantly Base Metal, 2 Surfaces
D5520 Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	D6605 Retainer Inlay - Cast Predominantly Base Metal, 3 or More Surfaces
D5611 Repair Resin Partial Denture Base, Mandibular	*D6606 Retainer Inlay - Cast Noble Metal, 2 Surfaces
D5612 Repair Resin Partial Denture Base, Maxillary	*D6607 Retainer Inlay - Cast Noble Metal, 3 or More Surfaces
D5621 Repair Cast Partial Framework, Mandibular	D6608 Retainer Onlay - Porcelain/Ceramic, 2 Surfaces
D5622 Repair Cast Partial Framework, Maxillary	D6609 Retainer Onlay - Porcelain/Ceramic, 3 or More Surfaces
D5630 Repair or Replace Broken Retentive/Clasping Material – Per Tooth	*D6610 Retainer Onlay - Cast High Noble Metal, 2 Surfaces
D5640 Replace Broken Teeth - Per Tooth	*D6611 Retainer Onlay - Cast High Noble Metal, 3 or More Surfaces
D5650 Add Tooth to Existing Partial Denture	D6612 Retainer Onlay - Cast Predominately Base Metal, 2 Surfaces
D5660 Add Clasp to Existing Partial Denture – Per Tooth	D6613 Retainer Onlay - Cast Predominately Base Metal, 3 or More Surfaces
D5670 Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary)	*D6614 Retainer Onlay - Cast Noble Metal, 2 Surfaces
D5671 Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular)	*D6615 Retainer Onlay - Cast Noble Metal, 3 or More Surfaces
D5710 Rebase Complete Maxillary Denture	D6710 Retainer Crown - Indirect Resin Based Composite
D5711 Rebase Complete Mandibular Denture	*D6720 Retainer Crown - Resin with High Noble Metal
D5720 Rebase Maxillary Partial Denture	D6721 Retainer Crown - Resin with Predominantly Base Metal
D5721 Rebase Mandibular Partial Denture	*D6722 Retainer Crown - Resin with Noble Metal
D5730 Reline Complete Maxillary Denture (Chairside)	*D6740 Retainer Crown - Porcelain/Ceramic
D5731 Reline Complete Mandibular Denture (Chairside)	*D6750 Retainer Crown - Porcelain Fused to High Noble Metal
D5740 Reline Maxillary Partial Denture (Chairside)	D6751 Retainer Crown - Porcelain Fused to Predominantly Base Metal
D5741 Reline Mandibular Partial Denture (Chairside)	*D6752 Retainer Crown - Porcelain Fused to Noble Metal
D5750 Reline Complete Maxillary Denture (Laboratory)	*D6780 Retainer Crown - $\frac{3}{4}$ Cast High Noble Metal
D5751 Reline Complete Mandibular Denture (Laboratory)	D6781 Retainer Crown - $\frac{3}{4}$ Cast Predominately Base Metal
D5760 Reline Maxillary Partial Denture (Laboratory)	*D6782 Retainer Crown - $\frac{3}{4}$ Cast Noble Metal
D5761 Reline Mandibular Partial Denture (Laboratory)	*D6783 Retainer Crown - $\frac{3}{4}$ Porcelain/Ceramic
D5850 Tissue Conditioning, Maxillary	*D6790 Retainer Crown - Full Cast High Noble Metal
D5851 Tissue Conditioning, Mandibular	D6791 Retainer Crown - Full Cast Predominantly Base Metal
D5876 Add Metal Substructure to Acrylic Full Denture (per arch)	*D6792 Retainer Crown - Full Cast Noble Metal
Prosthodontics - Fixed	D6930 Re-cement or Re-bond Fixed Partial Denture
D6205 Pontic - Indirect Resin Based Composite	Miscellaneous
*D6210 Pontic - Cast High Noble Metal	D9222 Deep Sedation/General Anesthesia – First 15 Minutes
D6211 Pontic - Cast Predominantly Base Metal	D9223 Deep Sedation/General Anesthesia – Each Subsequent 15 Minute Increment
*D6212 Pontic - Cast Noble Metal	Class D - No Deductible, 24-Month Waiting Period, Limited To Covered Child
*D6240 Pontic - Porcelain Fused to High Noble Metal	Orthodontics
D6241 Pontic - Porcelain Fused to Predominantly Base Metal	D8070 Comprehensive Orthodontic Treatment of the Transitional Dentition
*D6242 Pontic-Porcelain Fused to Noble Metal	D8080 Comprehensive Orthodontic Treatment of the Adolescent Dentition
*D6245 Pontic - Porcelain/Ceramic	

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*
PO Box 21542
Eagan, MN 55121-9930

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.

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 Provisions *continued*

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: Formal Appeal

To request a formal appeal of a claim denial or other action, You, or an authorized representative acting on Your behalf, must file a written request for an appeal 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 an appeal should be sent to:

GEHA Connection Dental *Plus* Appeals
PO Box 21542
Eagan, MN 55121-9930
Fax 816-257-3268
Email GEHADentalAppeals@geha.com

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

Within thirty (30) days after We receive Your request for an appeal, the review will be made. Someone other than the person who processed or reviewed the original claim shall make the review of Your request for an appeal and will give no deference to the initial benefit decision. The review 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.

Claim Provisions *continued*

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

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

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

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

Level 2: Final Appeal

If a claim remains denied after a request for an appeal, You, or an authorized representative acting on Your behalf, shall have the right to request a final review of the denial or other action. To request a final review of a claim denial or other action, You must file a written request for final review postmarked within ninety (90) days after the date of Our formal review 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 final review, copy of Our letter and any new information. Requests for a final review should be sent to:

GEHA Connection Dental *Plus* Appeals
PO Box 21542
Eagan, MN 55121-9930
Fax 816-257-3268
Email GEHADentalAppeals@geha.com

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

Within thirty (30) days after We receive Your request for a final appeal review, the review shall be made. Someone other than the person(s) who processed or reviewed the earlier reconsideration request shall review all documents submitted to The Dental Plan and no deference will be given to any prior decision. The final review will take into account all information submitted by 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.

The decision on Our final 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.

Claim Provisions *continued*

If We relied on an internal rule, guideline, protocol or other similar criterion in denying Your request for final 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 final 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.

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.

Connection Programs – Value Added Benefit

For more information about Vision, Hearing and other Value Added 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.

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

Deductibles

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

Maximum Limits

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

Waiting Periods

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

Benefit Percentages

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