

GHI Dental

<http://www.ghi.com>



2007

Dental PPO Plan

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

Enrollment Options for this Plan:

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

High Option Plan Serving: All of New York and New Jersey counties of Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex and Union. Connecticut counties of Fairfield, Litchfield, New Haven. Pennsylvania counties Pike and Monroe.



Authorized for distribution by the:



**United States
Office of Personnel Management**

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

Introduction

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

This brochure describes the benefits of GHI under our contract OPM-06-00060-3 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

GHI
441 9th Avenue
New York, NY 10001
212-501-4444
www.ghi.com

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

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

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

This Plan and FEDVIP are not a part of the Federal Employees Health Benefits (FEHB) Program.

Table of contents

Program highlights.....	4
A choice of plans and options.....	4
Enroll through BENEFEDS.....	4
Coverage effective date.....	4
Pre-tax salary deduction for employees.....	4
Annual enrollment opportunity.....	4
Continued group coverage.....	4
Waiting period.....	4
Section 1 Eligibility.....	5
Federal employees.....	5
Federal annuitants.....	5
Survivor annuitants.....	5
Compensationers.....	5
Family members.....	5
Not eligible.....	5
Section 2 Enrollment.....	6
Enroll through BENEFEDS.....	6
Enrollment types.....	6
Opportunities to enroll or change enrollment.....	6
When coverage stops.....	8
Section 3 How you get care.....	9
Identification cards / Enrollment confirmation.....	9
Where you get covered care.....	9
Plan providers.....	9
In-network.....	9
Out-of-network.....	9
Pre-certification.....	9
Coordination of benefits.....	9
Service area.....	9
Section 4 Your cost for covered services.....	10
Deductible.....	10
Annual benefit maximum.....	10
In-network services.....	10
Out-of-network services.....	10
Emergency services.....	10
Section 5 Dental services and supplies.....	11
Class A Basic.....	11
Diagnostic and Treatment Services.....	11
Preventative Services.....	11
Additional Procedures Covered as Basic Services.....	12
Class B Intermediate.....	13
Minor Restorative Services.....	13
Endodontic Services.....	13
Periodontal Services.....	14
Prosthodontic Services.....	14
Oral Surgery.....	14
Class C Major.....	15
Major Restorative Services.....	15
Endodontic Services.....	16
Periodontal Services.....	16

Prosthodontic Services.....	16
Class D Orthodontic.....	18
Orthodontic Services - limited to children up to age 19	18
General Services	19
Anesthesia Services	19
Intravenous Sedation.....	19
Consultations	19
Office Visits.....	20
Medications.....	20
Post Surgical Services.....	20
Miscellaneous Services.....	20
Section 6 General exclusions – things we don’t cover.....	21
Section 7 The claims filing and disputed claims processes.....	23
Section 8 Definitions of terms we use in this brochure.....	25
Section 9 A Federal program that complements FEDVIP benefits.....	26
Stop health care fraud!	27
Summary of benefits for GHI - 2007	28
2007 Monthly rate information for GHI	29
2007 Bi-weekly rate information for GHI	29

FEDVIP Program highlights

A choice of plans and options	You can select from several national, and in some areas regional, Preferred Provider Organizations (PPO), and high and standard coverage options. Visit www.opm.gov/insure/dentalvision for more information.
Enroll through BENEFEDS	You enroll through the Internet at www.BENEFEDS.com . See page 6 for more information.
Coverage effective date	If you sign up for a dental and/or vision plan during the 2006 Open Season, your coverage will begin on December 31, 2006. Premium deductions will start with the first full pay period beginning on/after January 1, 2007. You can use your benefits as soon as your coverage becomes effective.
Pre-tax salary deduction for employees	Employees automatically pay premiums through payroll deductions using pre-tax dollars. Annuitants automatically pay premiums through annuity deductions using post-tax dollars.
Annual enrollment opportunity	Each year you can enroll or change your dental and/or vision plan enrollment. This year the Open Season runs from November 13, 2006 through December 11, 2006. Other events allow for certain types of changes throughout the year. You do not need to re-enroll each open season unless you wish to change plans or plan options. Your coverage will continue from the previous year. See page 6 for more information.
Continued group coverage	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may be able to continue enrollment after your death. See page 5 for more information.
Waiting period	The only waiting period is for orthodontic services. To meet this requirement, the person receiving the services must be enrolled in the same plan for the entire waiting period.

Section 1 Eligibility

Federal employees	If you are a Federal or U.S. Postal Service employee, you are eligible to enroll in FEDVIP if you are eligible for the Federal Employees Health Benefits (FEHB) Program. Enrollment in the FEHB Program is not required.
Federal annuitants	<p>You are eligible to enroll if you:</p> <ul style="list-style-type: none">• retired on an immediate annuity under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS) or another retirement system for employees of the Federal Government;• retired for disability under CSRS, FERS, or another retirement system for employees of the Federal Government. <p>If you are an enrolled employee who subsequently retires on an immediate annuity or for disability under CSRS, FERS or another retirement system for employees of the Government, you may continue FEDVIP enrollment into retirement. There is no 5-year rule for continuing coverage into retirement as there is with the FEHB Program.</p>
Survivor annuitants	If you are a survivor of a deceased Federal/ U.S. Postal Service employee or annuitant and you are receiving an annuity, you can enroll or continue the enrollment of the deceased.
Compensationers	A compensationer is someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation Programs (OWCP) due to an on-the-job injury who is determined by the Secretary of Labor to be unable to return to duty. You are eligible to enroll in FEDVIP or continue FEDVIP enrollment into compensation status.
Family members	<p>Eligible family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.</p> <p>We don't determine who is eligible to enroll in, or who is eligible for coverage under, FEDVIP. Questions on eligibility must be directed to your employing agency or retirement system as they are responsible for eligibility determinations.</p>
Not eligible	<p>The following are not eligible to enroll in FEDVIP, regardless of FEHB eligibility or receipt of an annuity or portion of an annuity:</p> <ul style="list-style-type: none">• Deferred annuitants;• Former spouses of employees or annuitants;• FEHB temporary continuation of coverage (TCC) enrollees.

Section 2 Enrollment

Enroll through BENEFEDES

You must use BENEFEDES to enroll or change enrollment in a FEDVIP plan. BENEFEDES is a secure enrollment website (www.BENEFEDES.com) sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement system that pays your annuity), and the dental/vision plan you select. If you don't have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to enroll or change your enrollment. If you do not have access to a computer and you also do not have access to a phone, contact your employing office or retirement system for guidance on how to enroll or change your enrollment.

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

Enrollment types

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

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

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

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

Opportunities to enroll or change enrollment

Open season

If you are an eligible employee or an annuitant, you can enroll in a dental and/or vision plan during the November 13 through December 11, 2006 Open Season. Coverage is effective December 31, 2006.

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

New hire / Newly eligible

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

- a new employee;
- a previously ineligible employee who transferred to a covered position;
- a new survivor annuitant if not already covered under FEDVIP;

or within 60 days of a return to service following a break in service of at least 31 days.

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

Qualifying Life Event

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

The following chart lists the QLE's and the enrollment actions you may take.

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

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

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

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

Canceling an enrollment

You can cancel your enrollment only during the annual open season. An eligible family member's coverage also ends upon the effective date of the cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the open season effective date.

When coverage stops

Coverage ends when you:

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

Coverage for a family member ends when:

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

Under FEDVIP, there is no 31-day extension of coverage, temporary continuation of coverage, spouse equity coverage, or right to convert to an individual policy.

**FSAFEDS/High
Deductible Health Plans
and FEDVIP**

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

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

Current FSAFEDS participants must re-enroll to participate in 2007. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-800-952-0450.

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you can use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB and FEDVIP plans.

Section 3 How you get care

Identification cards / Enrollment confirmation	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider.</p> <p>If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 212/501-4GHI (4444). You may also request replacement cards through the GHI website, www.ghi.com</p>
Where you get covered care	<p>You get care from “Plan providers” You will only pay deductibles. You will not have to file claims.</p>
Plan providers	<p>We list Plan providers in the provider directory, which we update periodically. The list is on our website at: www.ghi.com</p>
In-network	<p>No referrals. No primary care dentist need be selected. Par dentist submit claim forms to GHI for payment.</p>
Out-of-network	<p>Members must submit claim form to GHI and GHI will reimburse members for covered services.</p>
Pre-certification	<p>Pre-certifications (also called pre-treatment estimates) are not mandatory, but GHI suggests pre-certification of benefits for procedures including surgeries, prosthetics, major restorations, orthodontics and other expensive treatments. Pre-certifications are recommended for treatment costing \$300 or more.</p>
Coordination of benefits	<p>If you have dental or vision coverage through your FEHB plan and coverage under FEDVIP, your FEHB plan will be the first payor of any benefit payments. We are responsible for coordinating benefits with the primary payor.</p> <p>We will also coordinate benefit payments with the payment of benefits under other group health benefits coverage you may have and the payment of dental costs under no-fault insurance that pays benefits without regard to fault.</p> <p>We may request that you verify/identify your health insurance plan(s) annually or at time of service.</p>
Service area	<p>To enroll in this Plan, you must live in our Service Area. This is where our providers practice. Our service area is: All of New York and New Jersey counties of Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex and Union. Connecticut counties of Fairfield, Litchfield, New Haven. Pennsylvania counties Pike and Monroe.</p> <p>Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other services out of our service area unless the services have prior plan approval.</p> <p>If you or a covered family member move outside of our service area, you can enroll in another plan. If your family members live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a Nationwide plan. If you or a family member move, you do not have to wait until Open Season to change plans. Contact BENEFEDS at www.BENEFEDS.com or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to change plans.</p>

Section 4 Your cost for covered services

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

Deductible	<p>A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.</p> <p>Example: In our Plan, the calendar year deductible for an individual is \$50 and family \$150</p>
Annual benefit maximum	<p>Once you reach this amount, you are responsible for all charges.</p> <p>This plan Annual maximum is \$1250 per covered person.</p>
In-network services	<p>GHI pays 100% of the preferred schedule of allowances to the GHI network provider for covered services.</p>
Out-of-network services	<p>Member must pay the difference of the GHI fee schedule and the dentist normal charges.</p>
Emergency services	<p>Does not apply</p>

Section 5 Dental services and supplies

Class A Basic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary and meet generally accepted dental protocols.
- There is no deductible for Basic services.
- The annual benefit maximum for Basic, Intermediate, Major and General services is \$1,250 per covered person.

You Pay:

- **High Option**

- In-Network:

GHI pays 100% of the Preferred Schedule of Allowances to the GHI Network Provider for the covered Basic Services listed below.

- Out-of-Network:

GHI reimburses you 100% of the Preferred Schedule of Allowances for the covered Basic Services. You are responsible to pay the difference between GHI's reimbursement and the Non-Network Provider's charge for covered services.

Diagnostic and Treatment Services

D0120 Periodic oral evaluation - *Limited to two in each calendar year.*

D0140 Limited oral evaluation - problem focused - *Limited to one every 12 consecutive months*

D0150 Comprehensive oral evaluation – patient - *Limited to one every 36 consecutive months for each dental provider.*

D0180 Comprehensive periodontal evaluation – patient - *Limited to one every 36 consecutive months for each dental provider.*

D0210 Intraoral - complete series (including bitewings) – *Limited to one every 36 consecutive months.*

D0220 Intraoral - periapical first film

D0230 Intraoral - periapical - each additional film

D0240 Intraoral - occlusal film

D0270 Bitewing - single film – *Limited to four bitewing x-rays in each calendar year.*

D0272 Bitewings - two films – *Limited to four bitewing x-rays in each calendar year.*

D0274 Bitewings - four films – *Limited to four bitewing x-rays in each calendar year.*

D0277 Vertical bitewings – 7 to 8 films

D0330 Panoramic film – *Limited to one every 36 consecutive months.*

D0425 Caries susceptibility tests

Preventative Services

D1110 Prophylaxis – adult - *Limited to two in each calendar year*

D1120 Prophylaxis – child - *Limited to two in each calendar year, to age 12.*

D1201 Topical application of fluoride (including prophylaxis) – child – *Prophylaxis limited to two in each calendar year. Fluoride limited to two treatments in 12 consecutive months, to age 19.*

D1203 Topical application of fluoride (excluding prophylaxis) – child - *Limited to two treatments in 12 consecutive months, to age 19.*

D1204 Topical application of fluoride (excluding prophylaxis) – adult - *Limited to two treatments in 12 consecutive months, to age 19.*

D1205 Topical application of fluoride (including prophylaxis) - adult - *Prophylaxis limited to two in each calendar year. Fluoride limited to two treatments in 12 consecutive months, to age 19.*

D1351 Sealant - per tooth - *Limited to permanent molars through age 18. One sealant per tooth in a 3-year period*

D1510 Space maintainer - fixed – unilateral - *Limited to one space maintainer per covered dependent child per lifetime. Eligible until the end of the calendar year in which the child reaches 19.*

D1515 Space maintainer - fixed – bilateral - *Limited to one space maintainer per covered dependent child per lifetime. Eligible until the end of the calendar year in which the child reaches 19.*

D1520 Space maintainer - removable – unilateral - *Limited to one space maintainer per covered dependent child per lifetime. Eligible until the end of the calendar year in which the child reaches 19.*

D1525 Space maintainer - removable – bilateral - *Limited to one space maintainer per covered dependent child per lifetime. Eligible until the end of the calendar year in which the child reaches 19.*

D1550 Re-cementation of space maintainer - *Eligible until the end of the calendar year in which the child reaches 19.*

Additional Procedures covered as Basic Services

D9110 Palliative treatment of dental pain – minor procedure – *Limited to one palliative service for each member in each calendar year.*

Not covered:

- *Plaque control programs*
 - *Oral hygiene instruction*
 - *Dietary instructions*
 - *Sealants for teeth other than permanent molars*
 - *Over-the-counter dental products, such as teeth whiteners, toothpaste, dental floss*
-

Class B Intermediate

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary and meet generally accepted dental protocols.
- The calendar year deductible is: \$50 per person (\$150 per family) for Intermediate, Major and General services (Class B & Class C).
- The annual benefit maximum for Basic, Intermediate, Major and General services is \$1,250 per covered person.

You Pay:

- **High Option**

- In-Network:

After you meet the annual deductible, GHI pays 100% of the Preferred Schedule of Allowances to the GHI Network Provider for covered Intermediate services listed below.

- Out-of-Network:

After you meet the annual deductible, GHI reimburses you 100% of the Preferred Schedule of Allowances for the covered Intermediate services listed below. You are responsible to pay the difference between GHI's reimbursement and the Non-Network Provider's charge for covered services.

Minor Restorative Services

D2140 Amalgam - one surface, primary or permanent

D2150 Amalgam - two surfaces, primary or permanent

D2160 Amalgam - three surfaces, primary or permanent

D2161 Amalgam - four or more surfaces, primary or permanent

D2330 Resin-based composite - one surface, anterior

D2331 Resin-based composite - two surfaces, anterior

D2332 Resin-based composite - three surfaces, anterior

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

D2910 Re-cement inlay - *Limited to once per 6 month period*

D2920 Re-cement crown - *Limited to once per 6 month period*

D2930 Prefabricated stainless steel crown - primary tooth - *Limited to one per patient, per tooth, per lifetime*

D2931 Prefabricated stainless steel crown - permanent tooth - *Limited to one per patient, per tooth, per lifetime*

D2951 Pin retention - per tooth, in addition to restoration

Not Covered:

- Restorations, including veneers, which are placed for cosmetic purposes only
- Gold foil restorations
- Temporary fillings

Endodontic Services

D3220 Therapeutic pulpotomy (excluding final restoration)

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

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

Periodontal Services

D4341 Periodontal scaling and root planning-four or more teeth per quadrant
D4342 Periodontal scaling and root planning-one to three teeth, per quadrant
D4910 Periodontal maintenance

Prosthodontic Services

D5410 Adjust complete denture - maxillary
D5411 Adjust complete denture - mandibular
D5421 Adjust partial denture - maxillary
D5422 Adjust partial denture - mandibular
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth - complete denture (each tooth)
D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth - per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5710 Rebase complete maxillary denture
D5720 Rebase maxillary partial denture
D5721 Rebase mandibular partial denture
D5730 Reline complete maxillary denture (chairside)
D5731 Reline complete mandibular denture (chairside)
D5740 Reline maxillary partial denture (chairside)
D5741 Reline mandibular partial denture (chairside)
D5750 Reline complete maxillary denture (laboratory)
D5751 Reline complete mandibular denture (laboratory)
D5760 Reline maxillary partial denture (laboratory)
D5761 Reline mandibular partial denture (laboratory) *Rebase/Reline - Limited to once in a 36-month period*
D5850 Tissue conditioning (maxillary)
D5851 Tissue conditioning (mandibular)
D6930 Recement fixed partial denture
D6980 Fixed partial denture repair, by report

Oral Surgery

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220 Removal of impacted tooth - soft tissue
D7230 Removal of impacted tooth - partially bony
D7240 Removal of impacted tooth - completely bony
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions - per quadrant
D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions - per quadrant
D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or toothe spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess - intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7971 Excision of pericoronal gingiva

Class C Major

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary and meet generally accepted dental protocols.
- The calendar year deductible is: \$50 per person (\$150 per family) for Intermediate, Major and General services (Class B & Class C).
- The annual benefit maximum for Basic, Intermediate, Major and General services is \$1,250 per covered person.

You Pay:

- **High Option**

- In-Network:

After you meet the annual deductible, GHI pays 100% of the Preferred Schedule of Allowances to the GHI Network Provider for covered Major services listed below.

- Out-of-Network:

After you meet the annual deductible, GHI reimburses you 100% of the Preferred Schedule of Allowances for the covered Major services listed below. You are responsible to pay the difference between GHI's reimbursement and the Non-Network Provider's charge for covered services.

Major Restorative Services

D0160 Detailed and extensive oral evaluation – problem focused, by report

D2542 Onlay - metallic - two surfaces

D2543 Onlay - metallic - three surfaces

D2544 Onlay - metallic - four or more surfaces

D2740 Crown - porcelain/ceramic substrate

D2750 Crown - porcelain fused to high noble metal

D2751 Crown - porcelain fused to predominately base metal

D2752 Crown - porcelain fused to noble metal

D2780 Crown - 3/4 cast high noble metal

D2781 Crown - 3/4 cast predominately base metal

D2783 Crown - 3/4 porcelain/ceramic

D2790 Crown - full cast high noble metal

D2791 Crown - full cast predominately base metal

D2792 Crown - full cast noble metal

D2794 Crown – titanium

D2950 Core buildup, including any pins

D2954 Prefabricated post and core, in addition to crown

D2980 Crown repair, by report

Not covered:

- *Gold foil restorations*
 - *Sedative restorations*
 - *Restorations for cosmetic purposes only*
 - *Composite resin inlays*
 - *Temporary crowns*
-

Endodontic Services

D3310 Anterior root canal (excluding final restoration)
D3320 Bicuspid root canal (excluding final restoration)
D3330 Molar root canal (excluding final restoration)
D3346 Retreatment of previous root canal therapy-anterior
D3347 Retreatment of previous root canal therapy-bicuspid
D3348 Retreatment of previous root canal therapy-molar
D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
D3410 Apicoectomy/periradicular surgery - anterior
D3421 Apicoectomy/periradicular surgery - bicuspid (first root)
D3425 Apicoectomy/periradicular surgery - molar (first root)
D3426 Apicoectomy/periradicular surgery (each additional root)
D3450 Root amputation - per root
D3920 Hemisection (including any root removal) - not including root canal therapy

Periodontal Services

D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces, per quadrant
D4211 Gingivectomy or gingivoplasty – one to three teeth, per quadrant
D4240 Gingival flap procedure, including root planing, four or more contiguous teeth or bounded teeth spaces per quadrant
D4249 Clinical crown lengthening-hard tissue
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant
D4270 Pedicle soft tissue graft procedure
D4271 Free soft tissue graft procedure (including donor site surgery)
D4273 Subepithelial connective tissue graft procedures (including donor site surgery)
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis - <i>Limited to once per lifetime</i>

Prosthodontic Services

D5110 Complete denture - maxillary
D5120 Complete denture - mandibular
D5130 Immediate denture - maxillary
D5140 Immediate denture - mandibular
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)
D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth)
D6210 Pontic - cast high noble metal
D6211 Pontic - cast predominately base metal
D6212 Pontic - cast noble metal
D6214 Pontic – titanium
D6240 Pontic - porcelain fused to high noble metal
D6241 Pontic - porcelain fused to predominately base metal
D6242 Pontic - porcelain fused to noble metal
D6245 Pontic - porcelain/ceramic
D6519 Inlay/onlay – porcelain/ceramic
D6520 Inlay – metallic – two surfaces
D6530 Inlay – metallic – three or more surfaces
D6543 Onlay – metallic – three surfaces
D6544 Onlay – metallic – four or more surfaces

D6545 Retainer - cast metal for resin bonded fixed prosthesis
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6740 Crown - porcelain/ceramic
D6750 Crown - porcelain fused to high noble metal
D6751 Crown - porcelain fused to predominately base metal
D6752 Crown - porcelain fused to noble metal
D6780 Crown - 3/4 cast high noble metal
D6781 Crown - 3/4 cast predominately base metal
D6782 Crown - 3/4 cast noble metal
D6783 Crown - 3/4 porcelain/ceramic
D6790 Crown - full cast high noble metal
D6791 Crown - full cast predominately base metal
D6792 Crown - full cast noble metal
D6973 Core buildup for retainer, including any pins

Not covered:

- *Implantology and related services except coverage for reimbursement of implants as an alternative benefit as a three unit fixed partial denture*
 - *Cast unilateral removable partial dentures*
 - *Precision attachments, personalization, precious metal bases, and other specialized techniques*
 - *Replacement of dentures that have been lost, stolen or misplaced*
 - *Removable or fixed prostheses initiated prior to the effective date of coverage or inserted/cemented after the coverage ending date*
-

Class D Orthodontic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary and meet generally accepted dental protocols.
- There is no calendar year deductible for Orthodontic services.
- The waiting period for orthodontic services is 12 months. The person receiving services must be covered under this Plan for the entire waiting period.
- The lifetime maximum for orthodontic services is \$2,000.
- The annual benefit maximum does not apply to Orthodontic services.

You Pay:

- **High Option**

- In-Network:

The participating network dentist will accept GHI's payment as payment in full for the first 20 months of covered comprehensive orthodontic treatment. GHI will issue payment directly to the participating network practice. There is no limit on the total number of months required for the completion of a full course of orthodontic treatment. For any remaining treatment time, the subscriber is responsible to pay the provider's charge.

- Out-of-Network:

GHI will issue payment to the subscriber for the first twenty (20) months of active comprehensive orthodontic treatment. The subscriber is responsible for claim submission to GHI, and GHI will issue payment directly to the subscriber. There is no limit on the total number of months required for the completion of a full course of orthodontic treatment. The subscriber is responsible to pay the difference between GHI's reimbursement and the non-network provider's charge for services.

Orthodontic Services - limited to children up to age 19

D8010 Limited orthodontic treatment of the primary dentition

D8020 Limited orthodontic treatment of the transitional dentition

D8030 Limited orthodontic treatment of the adolescent dentition

D8050 Interceptive orthodontic treatment of the primary dentition

D8060 Interceptive orthodontic treatment of the transitional dentition

D8070 Comprehensive orthodontic treatment of the transitional dentition

D8080 Comprehensive orthodontic treatment of the adolescent dentition

D8210 Removable appliance therapy

D8220 Fixed appliance therapy

D8660 Pre-orthodontic treatment visit

D8670 Periodic orthodontic treatment visit (as part of contract)

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

Not covered:

- *Orthodontic care for persons age 19 and over*
 - *Repair of damaged orthodontic appliances*
 - *Replacement of lost or missing appliance*
 - *Missed appointments*
 - *Habit control appliances*
 - *Addition charges for cosmetic banding options*
 - *Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth*
-

General Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary and meet generally accepted dental protocols.
- The calendar year deductible is: \$50 per person (\$150 per family) for Intermediate, Major and General services.
- The annual benefit maximum for Basic, Intermediate, Major and General services is \$1,250 per covered person.

You Pay:

- **High Option**

- In-Network:

After you meet the annual deductible, GHI pays 100% of the Preferred Schedule of Allowances to the GHI Network Provider for covered General services listed below.

- Out-of-Network:

After you meet the annual deductible, GHI reimburses you 100% of the Preferred Schedule of Allowances for the covered General services listed below. You are responsible to pay the difference between GHI's reimbursement and the Non-Network Provider's charge for covered services.

Anesthesia Services

D9220 Deep sedation/general anesthesia - first 30 minutes

D9221 Deep sedation/general anesthesia - each additional 15 minutes

Intravenous Sedation

D9241 Intravenous conscious sedation/analgesia - first 30 minutes

D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes

Consultations

D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)

Office Visits

D9440 Office visit - after regularly scheduled hours

Medications

D9610 Therapeutic drug injection, by report

Post Surgical Services

D9930 Treatment of complications (post-surgical) unusual circumstances, by report

Miscellaneous Services

D9940 Occlusal guard, by report - *Limited to one per 12 month period for patients age 13 or over*

D9941 Fabrication of athletic mouthguard - *Limited to one per 12 month period*

D9974 Internal bleaching - per tooth - *Limited to once per tooth per three year period*

Not covered:

- *Nitrous oxide*
 - *Oral sedation*
-

Section 6 General exclusions – things we don't cover

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

We do not cover the following:

- Any dental service or treatment not specifically listed as a covered service;
- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Services and treatment which are experimental or investigational;
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the law or regulation of any governmental unit. This exclusion applies whether or not you claim the benefits or compensation;
- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;
- Services and treatment performed prior to your effective coverage date including orthodontic treatment;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatment which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist (Services determined to be unnecessary or which do not meet accepted standards of dental practice are not billable to you by a participating dentist unless the dentist notifies you of your liability prior to treatment and you choose to receive the treatment. Participating dentists should document such notification in their records.);
- Services and treatment not meeting accepted standards of dental practice;

- Services and treatment resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/ mailing copies of your records, charts or x-rays;
- State or territorial taxes on dental services performed;
- Adjunctive dental care services are covered by other medical insurance even when provided by a general dentist or oral surgeon.
- Care furnished without charge to the patient.
- Habit breaking devices, or adjustment thereof.
- Services subject to no-fault automobile insurance.
- Treatment plans or rendered services that include surgeries, prosthetics, major restorations, orthodontics and other high-dollar treatments are subject to professional claim review to assess benefit amounts and determine if alternate benefits apply.
- When a more costly material or service is substituted for a less costly material or service having the same function, the allowance for the less costly material or service will be applied.

Section 7 The claims filing and disputed claims processes

How to file a claim for covered services

When you must file a claim – such as for services you received outside the Plan’s service area - submit the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN), and
- Receipts, if you paid for your services.

Submit your claims to:

Group Health Inc.
P.O. Box 2838

New York, New York 10116-2838

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Disputed Claims Process

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">(a) Write to us within 6 months from the date of our decision; and(b) Send your request to us at: GHI Customer Service Department, 441 Ninth Avenue, New York, NY 10001; and(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, dental records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we received your request to:</p> <ul style="list-style-type: none">(a) Pay the claim (or, if applicable, arrange for the dental care provider to give you the care); or(b) Write to you and maintain our denial -- go to step 4; or(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>If the dispute is not resolved through the reconsideration process, you may request a review of the denial. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our final decision, you may request an independent third party, mutually agreed upon by us and OPM, review the decision.</p> <p>The decision of the independent third party is binding and is the final review of your claim. <u>This decision is not subject to judicial review.</u></p>

Section 8 Definitions of terms we use in this brochure

Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this contract.
Annual benefit maximum	The maximum annual benefit that you can receive per person.
Class A services	Basic services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
Class B services	Intermediate services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
Class C services	Major services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
Class D services	Orthodontic services.
Deductible	The amount of covered expenses that you pay before we begin to pay.
Enrollee	The Federal employee or annuitant enrolled in this Plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Plan allowance	The amount we use to determine our payment for out-of-network services. We determine our plan allowance as follows:
Waiting period	The amount of time that you must be enrolled in this Plan before you can receive orthodontic services.
We / Us	This Plan.
You	Enrollee or eligible family member.

Section 9 A Federal program that complements FEDVIP benefits

Because you're reading this brochure, you're obviously considering enrolling (or are enrolled) in FEDVIP. Employees in the Executive Branch and in certain non-Executive Branch agencies should also consider enrolling in another program that complements the FEDVIP -- the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**.

The FSAFEDS Health Care Flexible Spending Account (HCFSAs) and Limited Expense Health Care Flexible Spending Account (LEX HCFSAs) give enrolled employees the opportunity to set aside pre-tax money from their paychecks to pay for a variety of eligible out-of-pocket medical (including dental and vision) expenses (for the HCFSAs) and eligible dental and vision expenses (for the LEX HCFSAs) for themselves and their eligible dependents.

As you can see elsewhere in this brochure, you will still have some out-of-pocket expenses with a FEDVIP plan. Why not pay for those expenses with pre-tax funds? Enroll in FSAFEDS!

About the FSAFEDS Health Care FSAs

- If you are eligible for FEHB and employed by an Executive Branch agency or other agency that has adopted FSAFEDS, even if you are not enrolled in FEHB or FEDVIP, you are eligible to participate in FSAFEDS.
- If you are enrolled in a traditional health plan (not a High Deductible plan), you may enroll in a general purpose HCFSAs (for eligible medical, dental and vision expenses).
- If you are enrolled in a High Deductible Health Plan (HDHP) with Health Savings Account (HSA), you may enroll in a LEX HCFSAs (for eligible dental and vision expenses only).
- The maximum annual amount you can allot to an FSAFEDS account is \$5,000.

Positive Reenrollment Required

You **must make an election to enroll in an FSA during Open Season**. Even if you enrolled for 2006, you must make a **new election** to continue participating in 2007.

How much to contribute

Before you determine a contribution amount for a HCFSAs, first review the level of coverage available to you through your FEHB plan. Don't forget to consider related coinsurance, copays, and/or other out-of-pocket expenses.

Second, for HCFSAs and LEX HCFSAs, think about your dental and vision out-of-pocket expenses. If you were in FSAFEDS last year, you probably used your account for dental and vision expenses. If you're now going to enroll in FEDVIP, you may have significant changes in your annual expenses. Be sure to reflect those changes in your annual FSAFEDS election. Insurance premiums are not eligible expenses for an FSA.

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

Enroll in FSAFEDS during Open Season

Enrollment is easy!

Online: visit www.FSAFEDS.com and click on Enroll.

Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), TTY: 1-800-952-0450, Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and non-Executive Branch employees whose employers have signed on to participate. **Under IRS law, FSAs are not available to annuitants.** Also, the U.S. Postal Service, Federal Reserve and the Judicial Branch, among others, have their own FSA plans with slightly different rules. However, the advantages of having an FSA are the same regardless of your agency.

To learn more about FSAFEDS, visit the website at www.FSAFEDS.com

Stop health care fraud!

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, plan, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your explanations of benefits (EOBs) statements.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-888-456-3728 and explain the situation.

Summary of benefits for GHI - 2007

- **Do not rely on this chart alone.** On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, please visit www.BENEFEDS.com or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680.
- Below, an asterisk (*) means the item is subject to the \$50/\$150 calendar year deductible.

High Option Benefits	You Pay In-network	You Pay Out of network	Page
Class A (Basic) Services – preventive and diagnostic	Nothing	GHI reimburses you 100% of the Preferred Schedule of Allowances.	11
Class B (Intermediate) Services – includes minor restorative services	After you meet the annual deductible, GHI pays 100% of the Preferred Schedule of Allowances *	After you meet the annual deductible, GHI reimburses you 100% of the Preferred Schedule *	13
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	After you meet the annual deductible, GHI pays 100% of the Preferred Schedule of Allowances *	After you meet the annual deductible, GHI reimburses you 100% of the Preferred Schedule of Allowances *	15
Class A, B, and C Services are subject to a \$1250 annual maximum benefit			
Class D Services – orthodontic \$2000 Lifetime Maximum	The participating network dentist will accept GHI's payment as payment in full for the first 20 months of covered treatment. For any remaining treatment time, you are responsible to pay the provider's charge.	You are responsible to pay the difference between GHI's reimbursement and the non-network provider's charge for covered services.	18

2007 Monthly rate information for GHI

How to find your monthly rate

Monthly Rates

Rating Area	High option Self Only	High option Self Plus One	High option Self and Family
1	\$35.62	\$71.24	\$106.84

2007 Bi-weekly rate information for GHI

How to find your bi-weekly rate

Bi-weekly Rates

Rating Area	High option Self Only	High option Self Plus One	High option Self and Family
1	\$16.44	\$32.88	\$49.31