Blue Cross Blue Shield FEP Dental[SM]

www.bcbsfepdental.com

1-855-504-2583

BlueCross BlueShield FEP Dental[SM]

2023

A Nationwide Dental PPO Plan

Who may enroll in this Plan: All Federal employees, annuitants, and certain TRICARE beneficiaries in the United States and overseas who are eligible to enroll in the Federal Employees Dental and Vision Insurance Program.

IMPORTANT
- Rates: Back Cover
- Summary of Benefits: Page 48

Enrollment Options for this Plan:

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

This Plan has 5 enrollment regions, including international; please see the end of this brochure to determine your region and corresponding rates

FEDVIP
Federal Employees
Dental And Vision Insurance Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
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 law 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. In response to the legislation, OPM established 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. Section 715 of the National Defense Authorization Act for Fiscal Year 2017 (FY 2017 NDAA), Public Law 114-38, expanded FEDVIP eligibility to certain TRICARE-eligible individuals.

This brochure describes the benefits of BCBS FEP Dental under the Blue Cross and Blue Shield Association's contract OPM02-FEDVIP-02AP-03 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

Blue Cross Blue Shield FEP Dental
PO Box 75
Minneapolis, MN 55440-0075
1-855-504-2583
www.bcbsfepdental.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, if they are also listed on the coverage. **You and your family members do not have a right to benefits that were available before January 1, 2023 unless those benefits are also shown in this brochure.**

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

BCBS FEP Dental is responsible for the selection of in-network providers in your area. Contact us at 1-855-504-2583, Dial 711 (for TTY relay services) for the names of participating providers or to request a zip code based provider directory. You may also view current in-network providers via our web site at www.bcbsfepdental.com which has a sophisticated provider search tool that allows you to select dentists according to a flexible set of criteria including location, proximity and specialty. Our online provider search tool is updated weekly and is available on a 24/7 basis. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not on a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in the BCBS FEP Dental network. If your provider is not currently participating in the provider network, you can nominate them to join. Provider nomination can be submitted online or on the mobile app. You can also print a nomination form from our website at www.bcbsfepdental.com or call us at 1-855-504-BLUE (2583) and we will send you a form. Bring the form to your dentist and ask them to complete it if they are interested in participating in our network. **You cannot change plans, outside of Open Season, because of changes to the provider network.**

Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If you require the services of a specialist and one is not available in your area, please contact us for assistance. Please be aware that the BCBS FEP Dental network may be different from the network of your health plan.

This BCBS FEP Dental Plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program.

We want you to know that protecting the confidentiality of your individually identifiable health information is of the utmost importance to us. To review full details about our privacy practices, our legal duties, and your rights, please visit our website at www.bcbsfepdental.com and link to the "Privacy Policies" at the bottom of the page. If you do not have access to the internet or would like further information, please contact us by calling 1-855-504-BLUE (2583) or 711 for TTY relay.

Discrimination is Against the Law

BCBS FEP Dental complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, BCBS FEP Dental does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

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Changes for 2023

Benefit Changes:

Changes for High Option

- You pay nothing for in-network Class B and C services for children 13 and under.

Changes for both High and Standard Options

- We cover overseas services at the in-network level.

FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas, regional dental Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) plans, and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Some TRICARE beneficiaries may not be eligible to enroll in both. Visit www.opm.gov/dental or www.opm.gov/vision for more information.
Enroll Through BENEFEDS	You enroll online at www.BENEFEDS.com. Please see Section 2, Enrollment, for more information.
Dual Enrollment	If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2022 Open Season, your coverage will begin on January 1, 2023. Premium deductions will start with the first full pay period beginning on/after January 1, 2023. You may use your benefits as soon as your enrollment is confirmed.
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. TRICARE enrollees automatically pay premiums through payroll deduction or automatic bank withdrawal (ABW) using post-tax dollars.
Annual Enrollment Opportunity	Each year, an Open Season will be held, during which you may enroll or change your dental and/or vision plan enrollment. This year, Open Season runs from November 14, 2022 through midnight EST December 12, 2022. 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. In addition to the annual Open Season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2, Enrollment, for more information.
Continued Group Coverage After Retirement	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 also be able to continue enrollment after your death. Please see Section 1, Eligibility, for more information.
Waiting Period	There are no waiting periods associated with the BCBS FEP Dental plan.

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 or the Health Insurance Marketplace (Exchange) and your position is not excluded by law or regulation, you are eligible to enroll in FEDVIP. Enrollment in the FEHB Program or a Health Insurance Marketplace (Exchange) plan is not required.

Federal Annuitants

You are eligible to enroll if you:

- 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.

Your FEDVIP enrollment will continue into retirement if you retire on an immediate annuity or for disability under CSRS, FERS or another retirement system for employees of the Government, regardless of the length of time you had FEDVIP coverage as an employee. There is no requirement to have coverage for 5 years of service prior to retirement in order to continue coverage into retirement, as there is with the FEHB Program.

Your FEDVIP coverage will end if you retire on a Minimum Retirement Age (MRA) + 10 retirement and postpone receipt of your annuity. You may enroll in FEDVIP again when you begin to receive your annuity.

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 may enroll or continue the existing enrollment.

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/illness 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.

TRICARE-eligible individual

An individual who is eligible for FEDVIP dental coverage based on the individual's eligibility to previously be covered under the TRICARE Retiree Dental Program or an individual eligible for FEDVIP vision coverage based on the individual's enrollment in a specified TRICARE health plan.

Retired members of the uniformed services and National Guard/Reserve components, including "gray-area" retirees under age 60 and their families are eligible for FEDVIP dental coverage. These individuals, if enrolled in a TRICARE health plan, are also eligible for FEDVIP vision coverage. In addition, uniformed services active-duty family members who are enrolled in a TRICARE health plan are eligible for FEDVIP vision coverage.

Family Members

Except with respect to TRICARE-eligible individuals, 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. FEDVIP rules and FEHB rules for family member eligibility are **NOT** the same. For more information on family member eligibility visit the website at www.opm.gov/healthcare-insurance/dental-vision/ or contact your employing agency or retirement system.

With respect to TRICARE-eligible individuals, family members include your spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in your legal custody by a court.

Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.

Not Eligible

The following persons are not eligible to enroll in FEDVIP, regardless of FEHB eligibility or receipt of an annuity or portion of an annuity:

- Deferred annuitants
- Former spouses of employees or annuitants.

Note: Former spouses of TRICARE-eligible individuals may enroll in a FEDVIP dental plan.

- FEHB Temporary Continuation of Coverage (TCC) enrollees
- Anyone receiving an insurable interest annuity who is not also an eligible family member
- Active-duty uniformed service members.

Note: If you are an active-duty uniformed service member, your dental and vision coverage will be provided by TRICARE. Your family members will still be eligible to enroll in the TRICARE Dental Plan (TDP).

Section 2 Enrollment

Enroll Through BENEFEDS

You must use BENEFEDS to enroll or change enrollment in a FEDVIP plan. BENEFEDS is a secure enrollment website (www.BENEFEDS.com) sponsored by OPM. If you do not 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 are currently enrolled in FEDVIP and do not want to change plans, your enrollment will continue automatically. Please Note: Your plans' premiums may change for 2023.

Note: You cannot enroll or change enrollment 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 BENEFEDS.

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 whom 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.

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

Dual Enrollment

If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee, annuitant, or TRICARE-eligible individual, you may enroll in a dental and/or vision plan during the November 14, through midnight EST December 12, 2022, Open Season. Coverage is effective January 1, 2023.

During future annual Open Seasons, you may enroll in a plan, or change or cancel 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 may enroll within 60 days after you become eligible as:

- a new employee;
- a previously ineligible employee who transferred to a covered position;
- a survivor annuitant if not already covered under FEDVIP; or
- an employee returning to service following a break in service of at least 31 days.
- a TRICARE-eligible individual

Qualifying Life Event

A qualifying life event (QLE) is an event that allows 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 QLEs and the enrollment actions you may take.

Qualifying Life Event: Marriage
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes

Qualifying Life Event: Acquiring an eligible family member (non-spouse)
From Not Enrolled to Enrolled: No
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Losing a covered family member
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: Yes
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Losing other dental/vision coverage (eligible or covered person)
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Moving out of regional plan's service area
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes

Qualifying Life Event: Going on active military duty, non- pay status (enrollee or spouse)
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: Yes
Change from One Plan to Another: No

Qualifying Life Event: Returning to pay status from active military duty (enrollee or spouse)
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Returning to pay status from Leave without pay
From Not Enrolled to Enrolled: **Yes (if enrollment cancelled during LWOP)**
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: **Yes (if enrollment cancelled during LWOP)**

Qualifying Life Event: Annuity/ compensation restored
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Transferring to an eligible position*
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: Yes
Change from One Plan to Another: No

*Position must be in a Federal agency that provides dental and/or vision coverage with 50 percent or more employer-paid premium.

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, except for enrollment because of loss of dental or vision insurance. 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 and confirms the enrollment or change. BENEFEDS will send you confirmation of your new coverage effective date.

Once you enroll in a plan, your 60-day window for that type of plan ends, even if 60 calendar days have not yet elapsed. That means once you have enrolled in either plan, you cannot change or cancel that particular enrollment until the next Open Season, unless you experience a QLE that allows such a change or cancellation.

Canceling an Enrollment

You may 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 for active and retired Federal, U.S. Postal employees, and TRICARE-eligible individuals when you:

- no longer meet the definition of an eligible employee, annuitant, or TRICARE-eligible individual;
- as a Retired Reservist you begin active duty;
- as sponsor or primary enrollee leaves active duty
- 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;
- cancel the enrollment during Open Season;
- a Retired Reservist begins active duty; or
- the sponsor or primary enrollee leaves active duty.

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.

NOTE: Coverage ends for a covered individual when BCBS FEP Dental does not receive premium payment for that covered individual.

Continuation of Coverage

Under FEDVIP, there is no 31-day extension of coverage. The following are also NOT available under the FEDVIP plans:

- Temporary Continuation of Coverage (TCC);
- spouse equity coverage; or
- right to convert to an individual policy (conversion policy).

FSAFEDS/High Deductible Health Plans and FEDVIP

If you are enrolled in an FSAFEDS HCFSA, you can take advantage of the Paperless Reimbursement option, which allows you to be reimbursed from your HCFSA without submitting an FSAFEDS claim. When BCBS FEP Dental receives a Federal Employees Dental Program claim for payment, we forward information about your out-of-pocket expenses (such as copayment and deductible amounts) to FSAFEDS for processing. FSAFEDS then reimburses you for your eligible out-of-pocket costs without the need for a claim form or receipt.

Using your FSA pre-tax dollars for your dental needs is a great way to get more out of your benefit dollar. BCBS FEP Dental will submit your eligible FSAFEDS out-of-pocket expenses electronically via Paperless Reimbursement (PR). To enroll in PR, visit www.FSAFEDS.com and click on My Account Summary, then Paperless Reimbursement. Please note that insurance premiums are not eligible expenses for either type of FSA.

If you have an HCFSA or LEX HCFSA FSAFEDS account and you haven't exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over up to $610 of unspent funds into another health care or limited expense account for the subsequent year. To be eligible for carryover, you must be employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31. You must also actively reenroll in a health care or limited expense account during the NEXT Open Season to be carryover eligible. Your reenrollment must be for at least the minimum of $100. If you do not reenroll, or if you are not employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st, your funds will not be carried over.

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.

For a health care or limited expense account, each participant must contribute a minimum of $100 to a maximum of $3,050.

Current FSAFEDS participants must re-enroll to participate next year. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-866-353-8058. **Note: FSAFEDS is not open to retired employees, or to TRICARE eligible individuals.**

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. You will be required to submit your claim to the FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA).

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation

When you enroll for the first time, you will receive a welcome letter along with an identification card ("ID Card") which will serve as confirmation of your enrollment. Each employee will receive 1 set of 2 BCBS FEP Dental ID cards. The ID cards will have the employee's name only on the ID cards. It is important to bring your FEDVIP and FEHB (if applicable) ID cards to every dental appointment because most FEHB plans offer some level of dental benefits separate from your FEDVIP coverage. Presenting both ID cards can ensure prompt payment of the maximum allowable benefits under each Program.

If you require a replacement ID card, you may order a replacement ID card via www.bcbsfepdental.com or you may call 1-855-504-2583. An ID card is neither a guarantee of benefits nor does your provider need it to render dental services. Your dentist may call 1-855-504-2583 to confirm your enrollment and the benefits available to you.

Where You Get Covered Care

You can obtain care from any licensed dentist in the United States or overseas.

Plan Providers

Our website, www.bcbsfepdental.com, has a sophisticated provider search tool that allows you to select dentists according to a flexible set of criteria including location, proximity and specialty. Our online provider search directory is updated weekly and is available on a 24/7 basis. You may also contact us at 1-855-504-2583 for the names of participating providers or to request a provider directory.

When you make your appointment, please advise the dentist office that you are enrolled in the BCBS FEP Dental plan and wish to use your in-network benefits. This will also serve to confirm that the dentist is a BCBS FEP Dental provider. **Note:** BCBS FEP Dental providers may work out of several locations, be sure to check that any location that is not listed on our online provider search tool is participating to ensure you receive in-network benefits.

Also, be sure to give the provider your FEHB information (if applicable).

You do not have to select a primary care dentist to receive benefits. You are free to choose the dentist you want for your dental care. However, your dentist choice can make a difference in the benefits you receive and the amount you pay. You may have additional out-of-pocket costs if your dentist is not an in-network provider.

In-Network

When you use a BCBS FEP Dental network provider, benefits are provided at the in-network level. You are responsible only for covered charges up to our Maximum Allowed Amount per procedure. You are not responsible for the difference between our Maximum Allowed Amount and the billed charges. BCBS FEP Dental's network consists of independently credentialed and contracted providers. To find a dentist in your area go to www.bcbsfepdental.com. You may also contact customer service at 1-855-504-2583.

Note: The BCBS FEP Dental provider network may be different from the FEP medical network. Be sure to locate an in-network provider on the web site provided above.

Only providers listed with their corresponding locations are in-network. Not all dentists at a location may be in-network and the same provider at a different location may not be in-network. It is your responsibility to ensure that the listed provider is active and in-network at the time and location at which you receive services.

Out-of-Network

You may obtain care from any licensed dentist. If the dentist you use is not part of our network, benefits will be determined based on the out-of-network benefit level. Because these providers are out of our network, payment will be based on the lesser of the provider's actual charge or the maximum allowed amounts established by BCBS FEP Dental for services rendered by out-of-network providers. You are responsible for the difference between our payment and the amount billed. If a member chooses to go out of network, payment will be made directly to the member.

Emergency Services

All expenses for emergency services are payable as any other expense, subject to plan provisions. If you receive emergency services from an out-of-network dentist, benefits will be paid under the out-of-network plan provisions. You are responsible for the difference between the maximum allowed amount and the billed charge.

Maximum Amount Allowed

The maximum amount of reimbursement we allow for a specific procedure. When you use an in-network provider, the provider cannot bill you for the difference between the Maximum Allowed Amount and the billed charge. When you use an out-of-network provider, you are responsible for the difference between the Maximum Allowed Amount and the billed charge in addition to applicable coinsurance and deductible amounts.

Precertification

Precertification, also known as pre-treatment estimate, is not mandatory. Although pre-treatment estimates are not required BCBS FEP Dental strongly recommends and highly encourages pre-treatment estimates be submitted for all major and extensive services prior to treatment. Major Services are subject to licensed professional review. Such review may include but not be limited to the following services: extensive oral surgery, periodontal, major restorative (crowns, bridges, inlays/onlays), endodontic, prosthodontic, implants and related treatments, and orthodontics. Extensive and clinically involved treatment plans will require additional supporting documentation such as chart notes, x-rays also known as radiographic images, photos, and may alternate to a least costly professionally acceptable procedure.

We will provide a non-binding, explanation of benefits to both you and your dentist that will indicate if procedures are covered and an estimate of what we will pay for those specific services. The estimated Maximum Allowable Amount is based on your current eligibility and contract benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or the contract may alter final payment. A pretreatment estimate is not a guarantee of benefits.

The final determination of eligibility is determined when the claim process. Please note that you are not required to submit pretreatment estimates to your FEHB carrier. They may be submitted directly to BCBS FEP Dental at:

BCBS FEP Dental
P.O. Box 75
Minneapolis, MN 55440-0075

Alternate Benefit

In some cases, you and your dental practitioner have a choice of treatment options and if more than one service can be used to treat your dental condition, we may decide to only authorize alternate treatment for a less costly covered service if the service selected is an appropriate method of treatment. This benefit application is done in an effort to keep your dental premiums affordable and assure you have coverage for the most common types of dental treatment. The dental plan limits benefits 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. 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 alternate benefit.

If you and your dentist choose the more expensive treatment instead of the alternate benefit, you are responsible for the additional charges beyond the allowance for the alternate service, even if an in-network provider provides services. This means that any difference between the alternate benefit and the charge actually incurred is your responsibility, including any applicable coinsurance.

BCBS FEP Dental recommends receiving a pre-treatment estimate prior to receiving services so you and your dental provider are aware of the coverage terms and benefits. For example, if the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. An implant is a covered procedure of the plan only if determined to be dentally necessary and least expensive appropriate treatment. We will review the clinical documentation submitted by your treating dentist. If the dental consultant determines the implant is not dentally necessary or a less expensive appropriate treatment is available no benefits will be allowed for the individual implant or implant procedures, and the allowance for the less expensive treatment may be approved. For example, full mouth reconstruction is not a covered benefit.

Dental Review

BCBS FEP Dental's claim review is conducted by licensed dental professionals who review the clinical documentation submitted by your treating dentist.

These licensed dental professionals will review necessary clinical notes and diagnostic images checking for dental necessity for procedures including but not limited to onlays, crowns, build ups, bridges, implants, periodontal treatment, extractions and anesthesia. The licensed dental professionals may extend an alternate benefit equivalent to that of another professionally acceptable form of treatment in accordance with the terms of the BCBS FEP Dental Plan.

The member has the right to appeal any unfavorable clinical decision provided that new additional supporting documentation has been received. The member's dental provider can appeal on the member's behalf.

FEHB First Payor

If you have dental coverage through your FEHB plan and coverage under BCBS FEP Dental, your FEHB plan will be the first payor of any benefit payments. When services are rendered by a provider who participates with both your FEHB and your BCBS FEP Dental plan, the BCBS FEP Dental Maximum Allowed Amount will be the prevailing charge, in these cases. We are responsible for facilitating the process if the primary FEHB payor is Blue Cross Blue Shield Service Benefit Plan. You are responsible for the difference between the FEHB and BCBS FEP Dental benefit payments and the BCBS FEP Dental Maximum Allowed Amount.

If you are covered under the Blue Cross Blue Shield Service Benefit Plan Basic Option and BCBS FEP Dental, you are not responsible for a $30 co-pay. If your provider collects the co-pay upfront, they are required to reimburse the co-pay in full once the claim has processed under BCBS FEP Dental.

It is important to bring your FEDVIP and FEHB (if applicable) identification cards to every dental appointment because most FEHB plans offer some level of dental benefits separate from your BCBS FEP Dental coverage. Presenting both identification cards can ensure that you receive prompt payment for the maximum allowable benefit under each Program. Please see the following examples.

Example 1: High Option coverage (In-Network provider). This example assumes all deductibles have been met and annual maximums have not been reached.

BCBS FEP Dental member with FEHB coverage – FEHB is always primary
Services are provided by an In-Network Provider
1-surface filling: $108.00
Maximum Allowable Amount: $60.00
FEHB payment (estimated): $16.00
BCBS FEP Dental benefits payable in the absence of FEHB coverage: $42.00 ($60.00 at 70%)
Payment by BCBS FEP Dental: $42.00
Member's responsibility: $2.00 ($60-$16-$42=$2.00)

Example 2: High Option coverage (Out-of-Network provider). This example assumes all deductibles have been met and annual maximums have not been reached.

BCBS FEP Dental member with FEHB coverage – FEHB is always primary
Services are provided by an Out-of-Network Provider
1-surface filling: $108.00*
FEHB payment (estimated): $16.00
BCBS FEP Dental benefits payable in the absence of FEHB coverage: $64.80 ($108.00 at 60%)
Payment by BCBS FEP Dental: $64.80
Member's responsibility: $27.20 ($108-$16-$64.80=$27.20)

*****Assumes provider charge is within the Maximum Allowed Amount

Coordination of Benefits

If you are covered under a non-FEHB plan, your BCBS FEP Dental benefits will be coordinated using traditional COB provisions for determining payment. Please see the following examples.

We will coordinate benefit payments with the payment of benefits under other group health benefits coverage (non-FEHB) you may have and the payment of dental costs under no-fault insurance that pays benefits without regard to fault.

Example 3: High Option coverage (In-Network provider). This example assumes all deductibles have been met and annual maximums have not been reached.

BCBS FEP Dental coverage is secondary to non-FEHB coverage
Services are provided by an In-Network Provider
2-surface filling: $121.00
Maximum Allowable Amount: $73.00
FEHB payment (estimated): $60.50
BCBS FEP Dental benefits payable in the absence of FEHB coverage: $51.10 ($73.00 at 70%)
Payment by BCBS FEP Dental: $12.50
Member's responsibility*****: $0.00 ($73-$60.50-$12.50=$0.00)
*****Assumes provider does not have a contractual relationship regarding fees with the primary carrier

Example 4: High Option coverage (Out-of-Network provider). This example assumes all deductibles have been met and annual maximums have not been reached.

BCBS FEP Dental coverage is secondary to non-FEHB coverage
Services are provided by an Out-of-Network Provider
2-surface filling: $121.00
FEHB payment (estimated): $96.80
BCBS FEP Dental benefits payable in the absence of FEHB coverage: $72.60 ($121.00 at 60%)
Payment by BCBS FEP Dental: $24.20
Member's responsibility*****: $0.00 ($121-$96.80-$24.20=$0.00)
*Assumes provider charge is within the Maximum Allowed Amount

Rating Areas

Your rates are determined based on where you live. This is called a rating area. If you move, you must update your address through BENEFEDS. Your rates might change because of the move. Your rates will not be impacted if you temporarily reside at another location.

Limited Access Area

If you live in a limited access area* (defined as driving distance greater than 15 miles urban areas/ greater than 35 miles in rural areas) and you receive covered dental services from an out-of-network provider, we will pay the same plan allowances as if you utilized an in-network provider. It is important to note that you will be responsible for the difference between the billed amount and our payment. Applying the Limited Access provision will not result in additional payment under the High Option orthodontic plan. If you have any questions about limited access areas or you are having problems locating an in-network dentist in your area, please call us at 1-855-504-2583.

***NOTE: Access Standards**

Limited Access does not apply to International Members.

Urban and suburban zip codes: at least 90% of FEDVIP eligibles in a network access area (zip code plus 15 driving-miles) must have access to a dental care preferred provider.

Rural zip codes: at least 80% of FEDVIP eligibles in a network access area (zip code plus 35 driving-miles) must have access to a dental care preferred provider.

Section 4 Your Cost For Covered Services

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

Deductible

A deductible is a fixed amount of expenses you must incur for certain covered services and supplies before we will pay for covered services. There is no family deductible limit. Covered charges credited to the deductible are also counted towards the Plan maximum and limitations.

Class A
In-Network High Option: $0
In-Network Standard Option: $0
Out-of-Network High Option: $50
Out-of-Network Standard Option: $75

Class B
In-Network High Option: $0
In-Network Standard Option: $0
Out-of-Network High Option: $50
Out-of-Network Standard Option: $75

Class C
In-Network High Option: $0
In-Network Standard Option: $0
Out-of-Network High Option: $50
Out-of-Network Standard Option: $75

Orthodontics
In-Network High Option: $0
In-Network Standard Option: $0
Out-of-Network High Option: $0
Out-of-Network Standard Option: $0

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you meet your deductible, if applicable.

Class A
In-Network High Option: 0%
In-Network Standard Option: 0%
Out-of-Network High Option: 10%
Out-of-Network Standard Option: 40%

Class B
In-Network High Option: 30%
In-Network Standard Option: 45%
Out-of-Network High Option: 40%
Out-of-Network Standard Option: 60%

Class C
In-Network High Option: 50%
In-Network Standard Option: 65%
Out-of-Network High Option: 60%
Out-of-Network Standard Option: 80%

Orthodontics
In-Network High Option: 50%
In-Network Standard Option: 50%
Out-of-Network High Option: 50%
Out-of-Network Standard Option: 50%

Annual Benefit Maximum

Once you reach this amount, you are responsible for all additional charges. The Annual Benefit Maximums within each option are combined between in and out-of-network services. The total Annual Benefit Maximum will never be greater than the In-Network Maximum Annual Benefit.

Maximum Annual Benefits:

In-Network High Option: Unlimited
In-Network Standard Option: $1,500
Out-of-Network High Option: $3,000
Out-of-Network Standard Option: $750

Lifetime Benefit Maximum

The Lifetime Maximum is applicable to Orthodontia benefits only. There are no other lifetime maximums under this Plan.

Lifetime Orthodontic Maximum

In-Network High Option: up to $3,500
In-Network Standard Option: up to $2,500
Out-of-Network High Option: up to $3,500
Out-of-Network Standard Option: up to $1,250

In-Network Services

You pay the coinsurance percentage of our network allowance for covered services. You are not responsible for charges above that allowance. To avoid any misunderstanding of the amount that you will owe, ask your dentist about his or her participation status in the BCBS FEP Dental network prior to receiving dental care.

Only providers listed with their corresponding locations are in network. Not all dentists at a location may be in network and the same provider at a different location may not be in network. It is your responsibility to ensure that the listed provider is active and in network at the time and location at which you receive services.

Out-of-Network Services

If the dentist you use is not part of our network, benefits will be considered at the out-of-network level. All services provided by an out-of-network dentist will be paid at out-of-network levels, except for limited access benefits. All benefit payments are based on BCBS FEP Dental's Maximum Allowable Amounts, which is a schedule of fixed dollar maximums established by BCBS FEP Dental for services by out-of-network providers. If a member chooses to go out of network, payments will be made directly to the member.

All out-of-network services listed in Section 5 are subject to the maximum allowable amount as defined by BCBS FEP Dental. The member is responsible for all remaining charges that exceed the allowable maximum.

Calendar Year

The calendar year refers to the plan year, which is defined as January 1, 2023 to December 31, 2023.

Emergency Services

Emergency services are defined as those dental services needed to relieve pain or prevent the worsening of a condition that would be caused by a delay.

In-Progress Treatment

In-progress treatment for dependents of retiring active duty service members who were enrolled in the TRICARE Dental Program (TDP) will be covered for the 2023 plan year; regardless of any current plan exclusion for care initiated prior to the enrollee's effective date.

This requirement includes assumption of payments for covered orthodontia services up to the FEDVIP policy limits, and full payment where applicable up to the terms of FEDVIP policy for covered services completed (but not initiated) in the 2023 plan year such as crowns and implants.

This is not a requirement for carriers to provide in-progress coverage for orthodontia in a plan where an enrollee must meet a waiting period.

FEDVIP carriers will not cover in-progress treatment if you enroll in a FEDVIP plan that has a waiting period, or does not cover the service. Several FEDVIP dental plans have options that offer orthodontia coverage without a 12-month waiting period, and without age limits.

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 determined to be necessary for the prevention, diagnosis, care, or treatment of a covered condition and if they are determined to meet generally accepted dental protocols.
- The calendar year deductible is $0 if you use an in-network provider. If you elect to use an out-of-network provider, the Standard Option has a $75 deductible per person; High Option has a $50 deductible. Neither Option contains a family deductible; each enrolled covered person must satisfy their own deductible.
- There is no High Option Annual Benefit Maximum for non-orthodontic in-network services, and $3,000 for out-of-network services.
- The Standard Option Annual Benefit Maximum for non-orthodontic services is $1,500 for in-network services and $750 for out-of-network services. In no instance will BCBS FEP Dental allow more than $1,500 in combined benefits under Standard Option in any plan year.
- All services requiring more than one visit are payable once all visits are completed.
- The frequencies between your FEHB and BCBS FEP Dental policy are combined not separate. (ex. If 2 oral exams are covered under your FEHB policy, and 2 oral exams are covered under BCBS FEP Dental a total of 2 oral exams will be covered and coverage will coordinate between both policies)
- The following list is an all-inclusive list of covered services. BCBS FEP Dental will provide benefits for these services, subject to the exclusions and limitations shown in this section and Section 7.

You Pay:

High Option

- **In-Network:** Preventive and Diagnostic services - $0 for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** Preventive and Diagnostic services – $50 deductible and then you pay 10% of the plan allowance, subject to plan maximums. You are responsible for any difference between our allowance and the billed amount.

Standard Option

- **In-Network:** Preventive and Diagnostic services - $0 for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** $75 deductible and then you pay 40% of the plan allowance, subject to plan maximums. You are responsible for any difference between our allowance and the billed amount.

Diagnostic and Treatment Services

Oral exams are limited to a combination of 2 per calendar-year

D0120 Periodic oral evaluation - Limit 2 during the calendar year for any combination of oral evaluations

D0140 Limited oral evaluation - problem focused - Limit 2 during the calendar year for any combination of oral evaluations

D0145 Oral evaluation for a patient under 3 years of age and counseling with a primary caregiver. Limit 2 during the calendar year for any combination of oral evaluations.

D0150 Comprehensive oral evaluation - new or established patient - Limit 2 during the calendar year for any combination of oral evaluations

Diagnostic and Treatment Services - continued on next page

Diagnostic and Treatment Services (cont.)
D0180 Comprehensive periodontal evaluation - Limit 2 during the calendar year for any combination of oral evaluations. If billed with a D4910, the D0180 will alternate to a D0120.
D0210 Intraoral - comprehensive series of radiographic images including bitewings - Limit 1 every 60 months
D0220 Intraoral - periapical radiographic image
D0230 Intraoral - periapical each additional radiographic image
D0240 Intraoral - occlusal radiographic image
D0250 Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector
D0251 Extra-oral - posterior dental radiographic image
D0270 Bitewing - single - radiographic image - Limit 2 per calendar year of any combination of bitewings for patients up to age 22, 1 per calendar year of any combination ofbitewings for all others
D0272 Bitewings - two radiographic images - Limit 2 per calendar year of any combination of bitewings for patients up to age 22, 1 per calendar year of any combination of bitewings for all others.
D0273 Bitewings - three radiographic images Limit - 2 per calendar year of any combination of bitewings for patients up to age 22, 1 per calendar year of any combination of bitewings for all others.
D0274 Bitewings - four radiographic images - Limit 2 per calendar year of any combination of bitewings for patients up to age 22, 1 per calendar year of any combination of bitewings for all others.
D0277 Bitewings - Seven to eight radiographic images - Limit 2 per calendar year for any combination of bitewings for patients up to age 22, 1 per calendar year for any combination of bitewings for all others.
D0330 Panoramic radiographic image - Limit 1 every 60 months
D0372 Intraoral tomosynthesis – comprehensive series of radiographic images - Limit 1 every 60 months
D0373 Intraoral tomosynthesis – bitewing radiographic image - Limit 2 per calendar year of any combination of bitewings for patients up to age 22, 1 per calendar year of any combination of bitewings for all others
D0374 Intraoral tomosynthesis – periapical radiographic image
D0425 Caries susceptibility tests
D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report
Preventive Services
D1110 Prophylaxis – Adult: Limit 3 during the calendar year. Age 13 and under will be processed as D1120 - additional information on the following page.
D1120 Prophylaxis – Child: Limit 3 during the calendar year. Age 14 and over will be processed as D1110 - additional information on the following page.
D1206 Topical application of fluoride - varnish - Limit 2 during the calendar year for patients up to age 22 in combination with D1208
D1208 Topical application of fluoride -excluding varnish - Limit 2 during the calendar year for patients up to age 22 in combination with D1206
D1351 Sealant - per tooth - unrestored permanent molars for patient up to age 22- any combination of a sealant or a preventive resin restoration - Limit 1 every 36 months
D1352 Preventive resin restoration in a moderate to high caries risk patient - unrestored - permanent tooth for patient up to age 22 - any combination of a sealant or a preventive resin restoration - Limit 1 every 36 months
D1353 Sealant repair - per unrestored permanent molar for patient up to age 22 - any combination of a sealant or preventive resin restoration - Limit 1 every 36 months
D1354 Application of caries arresting medicament per tooth
D1510 Space maintainer - fixed - unilateral - per quadrant - Limited to patients up to age 22
D1516 Space maintainer – fixed – bilateral, maxillary- Limited to patients up to age 22
D1517 Space maintainer – fixed – bilateral, mandibular - Limited to patients up to age 22
D1520 Space maintainer - removable - unilateral - per quadrant - Limited to patients up to age 22
D1526 Space maintainer – removable – bilateral, maxillary - Limited to patients up to age 22

Preventive Services - continued on next page

Preventive Services (cont.)

D1527 Space maintainer – removable – bilateral, mandibular - Limited to patients up to age 22

D1551 Re-cement or re-bond bilateral space maintainer - maxillary

D1552 Re-cement or re-bond bilateral space maintainer – mandibular

D1553 Re-cement or re-bond unilateral space maintainer – per quadrant

D1556 Removal of fixed unilateral space maintainer – per quadrant. Allowed if removed by dentist or dental practice that did not originally place the appliance

D1557 Removal of fixed bilateral space maintainer – maxillary. Allowed if removed by dentist or dental practice that did not originally place the appliance.

D1558 Removal of fixed bilateral space maintainer – mandibular. Allowed if removed by dentist or dental practice that did not originally place the appliance

D1575 Distal shoe space maintainer - Fixed – Unilateral - per quadrant - Limited to patients up to age 22

Additional Procedures Covered as Basic Services

D9110 Palliative treatment of dental pain – per visit - Not covered the same day as final treatment

D9310 Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)

D9311 Consultation with a medical health care professional

D9440 Office visit after regularly scheduled hours

Class A Basic Notes:

- All exams, oral evaluations and treatments such as fluorides are combined under one limitation under the plan. For example, periodic oral exam (D0120), oral evaluations (D0140), and comprehensive oral exam (D0150, D0180) are combined and limited to two examinations per year. If you have two exams and/or oral evaluations on the same date of service by the same dentist or dental office, only one of the exams will be reimbursed.
- Prophylaxis and scaling in presence of generalized moderate or severe gingival inflammation:
  - Limit 3 during the calendar year for any combination of D1110, D1120, and D4346, age 13 and under will be processed as D1120 and age 14 and over will be processed as D1110.
- One comprehensive evaluation per provider's office; additional comprehensive evaluations will be processed as a periodic evaluation
- 14 or more radiographic images on the same date of service will be processed as a D0210 (complete set of radiographic images). Bitewing radiographic images with the same date of service as a Panoramic radiographic image will be processed as a D0210.

Services Not Covered

Refer to Section 7 for a list of general exclusions

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 for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is $0 if you use an in-network provider.
- If you elect to use an out-of-network provider, Standard Option has a $75 deductible per person; High Option has a $50 deductible. Neither Option contains a family deductible, each enrolled covered person must satisfy their own deductible.
- There is no High Option Annual Benefit Maximum for non-orthodontic in-network services, and $3,000 for out-of-network services. However, alternate benefits may be applied. See Section 7 – Things We Do Not Cover, for a list of exclusions and limitations.
- The Standard Option Annual Benefit Maximum for non-orthodontic services is $1,500 for in-network services and $750 for out-of-network services. In no instance will BCBS FEP Dental allow more than $1,500 in combined benefits under Standard Option in any plan year.
- If more than one service or procedure can be used to treat the covered person's dental condition, BCBS FEP Dental may decide to only authorize alternative treatment for a less costly covered service or procedure if the service selected is an appropriate method of treatment. This may apply but not limited to include: a filing may be the alternate benefit of a crown or onlay, a removable partial denture may be an alternate benefit for implants. Should the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond the allowance for the alternate service, even if an in-network provider.
- A number of services listed in this section may be subject to Dental Review or an Alternate Benefit may be paid. We recommend that your dentist submit a pre-treatment estimate of benefits. To avoid expenses for services the plan will not cover, pre-treatment estimate of benefits accompanied by diagnostic quality pre-operative periapical radiographic images is encouraged. We will provide a non-binding, explanation of benefits to both you and your dentist that will indicate if procedures are covered and an estimate of what we will pay for those specific services. The estimated Maximum Allowable Amount is based on your current eligibility and contract benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or the contract may alter final payment. A pretreatment estimate is not a guarantee of benefits.
- For inlay services (D2610, D2620, D2630), if you decide to have the alternate benefit of a filling done, the time limitation would be 1 every 24 months.
- All services requiring more than one visit are payable once all visits are completed.
- The following list is an all-inclusive list of covered services. BCBS FEP Dental will provide benefits for these services, subject to the exclusions and limitations shown in this section and Section 7.
- In-progress treatment for dependents of retiring TDP enrollees will be covered for the 2023 plan year. This is regardless of any current plan exclusions for care initiated prior to the enrollee's effective date.

You Pay:

High Option

- **In-Network:** No deductible; you pay 30% of the plan allowance for covered services as defined by the plan subject to plan maximums. For children age 13 and under you pay $0 for covered services as defined by the plan subject to plan maximums.

- **Out-of-Network:** $50 deductible; you pay 40% of the plan allowance for covered services as defined by the plan, subject to plan maximums and any difference between our allowance and the billed amount.

Standard Option

- **In-Network:** No deductible; you pay 45% of the plan allowance for covered services as defined by the plan subject to plan maximums. For children age 13 and under, you pay $0 for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** $75 deductible; you pay 60% of the plan allowance for covered services as defined by the plan, subject to plan maximums and any difference between our allowance and the billed amount.

Minor Restorative Services

D2140 Amalgam – one surface, primary or permanent - Limit 1 every 24 months per surface per tooth

D2150 Amalgam – two surfaces, primary or permanent - Limit 1 every 24 month per surface per tooths

D2160 Amalgam – three surfaces, primary or permanent - Limit 1 every 24 months per surface per tooth

D2161 Amalgam – four or more surfaces, primary or permanent - Limit 1 every 24 months per surface per tooth

D2330 Resin-based composite – one surface, anterior - Limit 1 every 24 months per surface per tooth

D2331 Resin-based composite – two surfaces, anterior - Limit 1 every 24 months per surface per tooth

D2332 Resin-based composite – three surfaces, anterior - Limit 1 every 24 months per surface per tooth

D2335 Resin-based composite – four or more surfaces or involving incisal angle (anterior) - Limit 1 every 24 months per surface per tooth

D2390 Resin-based composite - resin crown anterior - Limit every 24 months per tooth

D2391 Resin-based composite – one surface, posterior - Limit 1 every 24 months per surface per tooth

D2392 Resin-based composite – two surfaces, posterior - Limit 1 every 24 months per surface per tooth

D2393 Resin-based composite – three surfaces, posterior - Limit 1 every 24 months per surface per tooth

D2394 Resin-based composite – four or more surfaces, posterior - Limit 1 every 24 months per surface per tooth

D2610 Inlay-porcelain/ceramic - one surface - Limit 1 every 60 months - **An alternate benefit will be provided**

D2620 Inlay-porcelain/ceramic - two surfaces - Limit 1 every 60 months - **An alternate benefit will be provided**

D2630 Inlay-porcelain/ceramic - three or more surfaces - Limit 1 every 60 months - **An alternate benefit will be provided**

D2910 Re-cement or re-bond inlay, onlay veneer or partial coverage restoration - Limit 1 every 6 months after initial installation, if less than 6 months from installation, no patient liability

D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core - Limit 1 every 6 months after initial installation, if less than 6 months from installation, no patient liability

D2920 Re-cement or re-bond crown - Limit 1 every 6 months after initial installation, if less than 6 months from installation, no patient liability

D2921 Re-attachment of tooth fragment, incisal edge or cusp - Limit to 1 every 24 months, included with fillings

D2928 Prefabricated porcelain/ceramic crown – permanent tooth – Limit 1 every tooth every 60 months for patients up to age 15 – **an alternate benefit will be provided**

D2929 Prefabricated porcelain/ceramic crown – primary tooth – Limit 1 per tooth every 60 months for patients up to age 15 - **an alternate benefit will be provided**

D2930 Prefabricated stainless steel crown - primary tooth – Limit 1 per tooth every 60 months for patients up to age 15, including crowns, bridges, prosthetics

D2931 Prefabricated stainless steel crown – permanent tooth – Limit 1 per tooth every 60 months for patients up to age 15, including crowns, bridges, prosthetics

D2940 Protective Restoration

D2941 Interim therapeutic restoration - primary dentition

D2951 Pin retention – per tooth, in addition to restoration

Minor Restorative Services - continued on next page

Minor Restorative Services (cont.)
D7288 Brush Biopsy - Limit 1 every 12 months
Endodontic Services
D3110 Pulp cap - direct (excluding final restoration)
D3120 Pulp cap - indirect (excluding final restoration)
D3220 Therapeutic pulpotomy (excluding final restoration) - Primary teeth only, 1 per lifetime
D3221 Pulpal debridement, primary and permanent teeth
D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development - 1 per lifetime
D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) - 1 per lifetime
D3240 Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) - 1 per lifetime
D3355 Pulpal regeneration initial visit
D3356 Pulpal regeneration interim medication replacement
D3357 Pulpal regeneration completion of treatment
Periodontal Services
D4341 Periodontal scaling and root planing - four or more teeth per quadrant - Limit 1 every 24 months
D4342 Periodontal scaling and root planing - one to three teeth per quadrant - Limit 1 every 24 months
D4346 Scaling in presence of generalized moderate or severe gingival inflammation - Full mouth, after oral exam - Limited 3 in combination with D1110 and/or D1120 during calendar year
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910 Periodontal maintenance - Limit 4 every12 months combined with adult prophylaxis, and scaling in presence of generalized moderate or severe gingival inflammation, after the completion of active periodontal therapy
D7921 Collect - Apply Autologous Product - Limit 1 in 36 months
Prosthodontic Services
D5410 Adjust complete denture – maxillary - Limit 1 per year beginning 6 months after the initial installation
D5411 Adjust complete denture – mandibular - Limit 1 per year beginning 6 months after the initial installation
D5421 Adjust partial denture – maxillary - Limit 1 per year beginning 6 months after the initial installation
D5422 Adjust partial denture – mandibular - Limit 1 per year beginning 6 months after the initial installation
D5511 Repair broken complete denture base mandibular - Limit 1 per year beginning 6 months after the initial installation
D5512 Repair broken complete denture base, maxillary - Limit 1 per year beginning 6 months after the initial installation
D5520 Replace missing or broken teeth – complete denture (each tooth) - Limit 1 per year beginning 6 months after the initial installation
D5611 Repair resin denture base mandibular - Limit 1 per year beginning 6 months after the initial installation
D5612 Repair resin partial denture base, maxillary - Limit 1 per year beginning 6 months after the initial installation
D5621 Repair cast framework, mandibular - Limit 1 per year beginning 6 months after the initial installation
D5622 Repair cast partial framework, maxillary - Limit 1 per year beginning 6 months after the initial installation
D5630 Repair or replace broken retentive/clasping materials per tooth - Limit 1 per year beginning 6 months after the initial installation
D5640 Replace broken teeth – per tooth - Limit 1 per year beginning 6 months after the initial installation
D5650 Add tooth to existing partial denture - Limit 1 per year beginning 6 months after the initial installation
D5660 Add clasp to existing partial denture - Limit 1 per year beginning 6 months after the initial installation
D5670 Replace all teeth and acrylic on cast metal framework, maxillary – Limit 2 every 24 months beginning 6 months after the initial installation
D5671 Replace all teeth and acrylic on cast metal framework, mandibular – Limit 2 every 24 months beginning 6 months after the initial installation
D5710 Rebase complete maxillary denture – Limit 1 every 36 months beginning 6 months after the initial installation
D5711 Rebase complete mandibular denture – Limit 1 every 36 months beginning 6 months after the initial installation

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D5720 Rebase maxillary partial denture – Limit 1 every 36 months beginning 6 months after the initial installation
D5721 Rebase mandibular partial denture - Limit 1 every 36 months beginning 6 months after the initial installation
D5725 Rebase hybrid prosthesis – Limit 1 every 36 months beginning 6 months after the initial installation
D5730 Reline complete maxillary denture (direct) – Limit 1 every 36 months beginning 6 months after the initial installation
D5731 Reline complete mandibular denture (direct) - – Limit 1 every 36 months beginning 6 months after the initial installation
D5740 Reline maxillary partial denture (direct) – Limit 1 every 36 months beginning 6 months after the initial installation
D5741 Reline mandibular partial denture (direct) – Limit 1 every 36 months beginning 6 months after the initial installation
D5750 Reline complete maxillary denture (indirect) – Limit 1 every 36 months beginning 6 months after the initial installation
D5751 Reline complete mandibular denture (indirect) – Limit 1 every 36 months beginning 6 months after the initial installation
D5760 Reline maxillary partial denture (indirect) – Limit 1 every 36 months beginning 6 months after the initial installation
D5761 Reline mandibular partial denture (indirect) – Limit 1 every 36 months beginning 6 months after the initial installation
D5765 Soft liner for complete or partial removable denture – indirect – Limit 1 every 36 months beginning 6 months after the initial installation.
D5850 Tissue conditioning (maxillary)
D5851 Tissue conditioning (mandibular)
D6096 Remove broken implant retaining screw – Limit 1 every 60 months
D6930 Re-cement or re-bond fixed partial denture - Limit 1 per bridge beginning 6 months after the initial installation
D6980 Fixed partial denture repair, by report
D9120 Fixed partial denture sectioning - 1 per 60 Months
Oral Surgery
D7111 Extraction coronal remnants, primary tooth
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
D7241 Removal of impacted tooth – completely bony with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy - intentional partial tooth removal, impacted teeth only
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7272 Tooth transplantation - includes splinting or stabilization
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 tooth spaces, per quadrant
D7471 Removal of exostosis
D7485 Surgical reduction of tuberosity

Oral Surgery - continued on next page

Oral Surgery (cont.)

D7510 Incision and drainage of abscess – intraoral soft tissue

D7910 Suture of recent small wounds up to 5 cm

D7953 Bone replacement graft for ridge preservation - per site - No review on anterior teeth. Posterior teeth reviewed to determine if covered or not. 3rd Molar extraction sites denied unless D7251 performed. Anterior teeth and approved posterior teeth, Limit 1 every 60 months

D7971 Excision of pericoronal gingiva

D7972 Reduction of fibrous tuberosity – Limit 1 every 6 months

D7999 Unspecified oral surgery procedure, by report

Class B Intermediate Notes:

- Restorations are covered benefits only when necessary to replace tooth structure due to fracture or decay.
- For reporting and benefit purposes, the completion date for crowns and fixed partial dentures is the cementation date. The completion date is the insertion date for removable prosthodontic appliances. For immediate dentures, the provider who fabricated the denture may be reimbursed for the service after insertion by another provider (e.g., oral surgeon).
- Tissue conditioning is considered inclusive when performed on the same day as the delivery of a denture or a reline/rebase.
- Bone replacement grafts for ridge preservation are limited to extraction sites when implants are approved for placement or when implant removal may be necessary.

Periodontal Services:

- Full mouth diagnostic quality radiographic images and/or a panoramic radiographic image including bitewings radiographs; labeled and dated (within 12 months of submitted procedure).
- Periodontal Charting: 6-point periodontal pocket depth charting as described by the ADA and AAP labeled and dated (within 12 months of submitted procedure).
- Teeth to be treated must demonstrate at least 4-millimeter pocket depths, bleeding on probing, with demonstrable radiographic evidence of bone loss (either vertical or horizontal) of the alveolar crest.
- Bone loss is considered to be a bone level that is greater 1.5mm apical to the CEJ (cementoenamel junction).
- Non-surgical periodontal and periodontal maintenance procedures will be disallowed with no patient responsibility when submitted on the same date of service as preventive prophylaxis procedures.

Services Not Covered

Refer to Section 7 for a list of general exclusions

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 for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is $0 if you use an in-network provider.
- If you elect to use an out-of-network provider, Standard Option has a $75 deductible per person; High Option has a $50 deductible. Neither Option contains a family deductible, each enrolled covered person must satisfy their own deductible.
- There is no High Option Annual Benefit Maximum for non-orthodontic in-network services, and $3,000 for out-of-network services.
- The Standard Option Annual Benefit Maximum for non-orthodontic services is $1,500 for in-network services and $750 for out-of-network services. In no instance will BCBS FEP Dental allow more than $1,500 in combined benefits under Standard Option in any plan year.
- If more than one service or procedure can be used to treat the covered person's dental condition, BCBS FEP Dental may decide to authorize alternate treatment for a less costly covered service or procedure if the service selected is an appropriate method of treatment. This may apply but not limited to include: a filing may be the alternate benefit of a crown or only, a removable partial denture may be an alternate benefit for implants. Should the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond the allowance for the alternate service, even if an in-network provider.
- A number of services listed in this section may be subject to dental review or an alternate benefit may be paid. We recommend that your dentist submit a pre-treatment estimate of benefits. To avoid expenses for services the plan will not cover, a pre-treatment estimate of benefits accompanied by diagnostic quality pre-operative periapical radiographic and/or panoramic images is encouraged. We will provide a non-binding, explanation of benefits to both you and your dentist that will indicate if procedures are covered and an estimate of what we will pay for those specific services. The estimated Maximum Allowable Amount is based on your current eligibility and contract benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or the contract may alter final payment. A pretreatment estimate is not a guarantee of benefits.
- For inlay services (D2510, D2520, D2530, D2650, D2651, D2652), if you decide to have the alternate benefit of a filling done, the time limitation would be 1 every 24 months.
- All services requiring more than one visit are payable once all visits are completed.
- The following list is an all-inclusive list of covered services. BCBS FEP Dental will provide benefits for these services, subject to the exclusions and limitations shown in this section and Section 7.
- In-progress treatment for dependents of retiring TDP enrollees will be covered for the 2023 plan year. This is regardless of any current plan exclusions for care initiated prior to the enrollee's effective date.

You Pay:

<u>High Option</u>

- **In-Network:** No deductible; you pay 50% of the plan allowance for covered services as defined by the plan subject to plan maximums. For children age 13 and under you pay $0 for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** $50 deductible; you pay 60% of the plan allowance for covered services as defined by the plan subject to plan maximums and any difference between our allowance and the billed amount**.**

Standard Option

- **In-Network:** No deductible; you pay 65% of the plan allowance for covered services as defined by the plan subject to plan maximums. For children age 13 and under, you pay $0 for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** $75 deductible; you pay 80% of the plan allowance for covered services as defined by the plan subject to plan maximums and any difference between our allowance and the billed amount.

Major Restorative Services

D0160 Detailed and extensive oral evaluation - problem focused, by report - Limit 2 during the calendar year for any combination of oral evaluations

D2410 Gold Foil – one surface – Limit 1 every 24 months - **An alternate benefit will be provided**

D2420 Gold Foil – two surfaces – Limit 1 every 24 months - **An alternate benefit will be provided**

D2430 Gold Foil – three surfaces – Limit 1 every 24 months - **An alternate benefit will be provided**

D2510 Inlay - metallic - one surface - Limit 1 per tooth every 60 months - **An alternate benefit will be provided**

D2520 Inlay - metallic - two surfaces -Limit 1 per tooth every 60 months - **An alternate benefit will be provided**

D2530 Inlay - metallic - three surfaces - Limit 1 per tooth every 60 months - **An alternate benefit will be provided**

D2542 Onlay - metallic - two surfaces - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

D2543 Onlay - metallic - three surfaces - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

D2544 Onlay - metallic - four or more surfaces - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

D2642 Onlay-porcelain/ceramic - two surfaces - Limit 1 per tooth every 60 months

D2643 Onlay-porcelain/ceramic - three surfaces - Limit 1 per tooth every 60 months

D2644 Onlay porcelain/ceramic - four or more surfaces - Limit 1 per tooth every 60 months

D2650 Inlay - resin-based composite - one surface, lab proc - Limit 1 every 60 months - **An alternate benefit will be provided**

D2651 Inlay - resin-based composite - two surfaces, lab proc - Limit 1 every 60 months - **An alternate benefit will be provided**

D2652 Inlay - resin-based composite - three surfaces, lab proc - Limit 1 every 60 months - **An alternate benefit will be provided**

D2662 Onlay - resin-based composite - two surfaces, lab proc - Limit 1 every 60 months

D2663 Onlay - resin-based composite - three surfaces, lab proc - Limit 1 per tooth every 60 months

D2664 Onlay - resin-based composite - four or more surfaces, lab proc - Limit 1 per tooth every 60 months

D2710 Crown - resin-based composite, lab proc - Limit 1 every 60 months

D2712 Crown - 3/4 resin-based composite, lab proc - Limit 1 per tooth every 60 months

D2720 Crown resin with high noble metal - Limit 1 per tooth every 60 months

D2721 Crown resin with predominantly base metal - Limit 1 per tooth every 60 months

D2722 Crown resin with noble metal - Limit 1 per tooth every 60 months

D2740 Crown - porcelain/ceramic - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

D2750 Crown - porcelain fused to high noble metal - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

D2751 Crown - porcelain fused to predominately base metal - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

D2752 Crown - porcelain fused to noble metal - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

D2753 Crown - porcelain fused to titanium and titanium alloys- Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

D2780 Crown - 3/4 cast high noble metal - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

D2781 Crown - 3/4 cast predominately base metal - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

D2782 Crown - 3/4 cast noble metal - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

D2783 Crown - 3/4 porcelain/ceramic - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics. Denied if done on an anterior tooth.

D2790 Crown - full cast high noble metal - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

D2791 Crown - full cast predominately base metal - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

D2792 Crown - full cast noble metal - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics

Major Restorative Services - continued on next page

Major Restorative Services (cont.)
D2794 Crown - titanium and titanium alloys - Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics
D2932 Crown prefabricated resin – Limit 1 per tooth every 60 months for patients up to age 15, including crowns, bridges, prosthetics
D2933 Crown prefabricated stainless steel crown/resin window - Limit 1 per tooth every 60 months for patients up to age of 15 - **alternate benefit will be provided**
D2934 Prefabricated esthetic coated stainless steel crown, primary tooth – Limit 1 per tooth every 60 months for patients, including crowns, bridges, prosthetics
D2950 Core buildup, including any pins - Limit 1 buildup procedure, per tooth every 60 months
D2952 Cast post and core in addition to crown - Limit 1 buildup procedure, every 60 months
D2954 Prefabricated post and core, in addition to crown - Limit 1 buildup procedure, per tooth every 60 months
D2955 Post removal, not in conjunction with endodontic
D2971 Additional procedures to customize a crown to fit under existing partial denture framework - Limit 1 every 60 months
D2980 Crown repair, by report – Limit 1 every 12 months
D2981 Inlay Repair - Limit 1 every 12 months
D2982 Onlay Repair – Limit 1 every 12 months
D2983 Veneer Repair – Limit 1 every 12 months
D2990 Resin infiltration of incipient smooth surface lesions
Endodontic Services
D3310 Anterior root canal (excluding final restoration)
D3320 Premolar 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 – premolar
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 – premolar (first root)
D3425 Apicoectomy/periradicular surgery – molar (first root)
D3426 Apicoectomy/periradicular surgery (each additional root)
D3430 Retrograde filling – per root
D3450 Root amputation – per root
D3471 Surgical repair of root resorption – anterior
D3472 Surgical repair of root resorption – premolar
D3473 Surgical repair of root resorption – molar
D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior
D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar
D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption – molar
D3920 Hemisection (including any root removal) – not including root canal therapy
D3921 Decoronation or submergence of an erupted tooth

Periodontal Services

D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces, per quadrant - Limit 1 every 36 months

D4211 Gingivectomy or gingivoplasty – one to three teeth, per quadrant – Limit 1 every 36 months

D4212 Gingivectomy or gingivoplasty - with restorative procedures, per tooth – Limit 1 every 36 months

D4240 Gingival flap procedure, including root planing, four or more contiguous teeth or tooth bounded spaces per quadrant – Limit 1 every 36 months

D4241 Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant – Limit 1 every 36 months

D4245 Apically positioned flap – permanent teeth only - Limit 1 every 36 months

D4249 Clinical crown lengthening – hard tissue

D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or tooth bounded spaces per quadrant – Limit 1 every 36 months

D4261 Osseous surgery (including flap entry and closure), one to three contiguous teeth or tooth bounded spaces per quadrant – Limit 1 every 36 months

D4263 Bone replacement graft – retained natural tooth - first site in quad – permanent teeth only - Limit 1 every 36 months

D4264 Bone replacement graft – retained natural tooth - each additional site in quad – permanent teeth only - Limit 1 every 36 months

D4268 Surgical revision procedure, per tooth

D4270 Pedicle soft tissue graft procedure – Limit 1 every 36 months

D4273 Autogenous connective tissue graft procedures first tooth (including donor and recipient surgical site) – Limit 1 every 36 months

D4274 Mesial/distal wedge procedure, single tooth – permanent teeth only - Limit 1 every 36 months

D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft - Limit 1 every 36 months

D4276 Combined connective tissue and pedicle graft, per tooth – Limit 1 every 36 months

D4277 Free soft tissue graft procedure, first tooth – Limit 1 every 36 months

D4278 Free soft tissue graft procedure - each additional contiguous tooth – Limit 1 every 36 months

D4283 Autogenous connective tissue graft procedure, each additional contiguous tooth (including donor and recipient surgical site) – Limit 1 every 36 months

D4285 Non-autogenous connective tissue graft procedure, each additional contiguous tooth (including recipient site and donor material) – Limit 1 every 36 months

D4355 Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis on a subsequent visit - Limit 1 per lifetime

D4999 Periodontal procedure, unspecified by report

Prosthodontic Services

D5110 Complete denture – maxillary – Limit 1 every 60 months – Denied if using as a temporary denture.

D5120 Complete denture - mandibular – Limit 1 every 60 months – Denied if using as a temporary denture.

D5130 Immediate denture – maxillary – Limit 1 every 60 months – Denied if using as a temporary denture.

D5140 Immediate denture - mandibular – Limit 1 every 60 months – Denied if using as a temporary denture.

D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) – Limit 1 every 60 months. Denied if using as a temporary denture.

D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) – Limit 1 every 60 months. Denied if using as a temporary denture.

D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) – Limit 1 every 60 months

D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) – Limit 1 every 60 months

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D5221 Immediate maxillary partial denture, resin base – (including retentive/clasping materials, rests and teeth) - Limit 1 every 60 months – Denied if using as a temporary denture.
D5222 Immediate mandibular partial denture, resin base – (including retentive/clasping materials, rests and teeth) - Limit 1 every 60 months – Denied if using as a temporary denture.
D5223 Immediate maxillary partial denture, cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) -Limit 1 every 60 months
D5224 Immediate mandibular partial denture, cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)- Limit 1 every 60 months
D5225 Maxillary partial denture – flexible base (including retentive/clasping materials, rests and teeth)– Limit 1 every 60 months - Denied if using as a temporary denture.
D5226 Mandibular partial denture – flexible base (including retentive/clasping materials, rests and teeth) – Limit 1 every 60 months - Denied if using as a temporary denture.
D5227 Immediate maxillary partial denture – flexible base (including any clasps, rest and teeth) – Limit 1 every 60 months – Denied if using as a temporary denture.
D5228 Immediate mandibular partial denture – flexible base (including any clasps, rest and teeth) – Limit 1 every 60 months – Denied if using as a temporary denture.
D5282 Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary - Limit 1 every 60 months
D5283 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular - Limit 1 every 60 months
D5863 Overdenture – complete maxillary - Limit 1 every 60 months **- an alternate benefit will be provided**
D5864 Overdenture – partial maxillary - Limit 1 every 60 months **- an alternate benefit will be provided**
D5865 Overdenture – complete mandibular - Limit 1 every 60 months **- an alternate benefit will be provided**
D5866 Overdenture – partial mandibular - Limit 1 every 60 months **- an alternate benefit will be provided**
D5876 Add metal substructure to acrylic full denture (per arch) – Limit 1 every 60 months
D6010 Surgical placement of implant body, endosteal implant – Limit 1 per tooth every 60 months
D6012 Surgical placement of interim implant body for transitional prosthesis: endosteal implant– Limit 1 per site every 60 months
D6013 Surgical placement of mini implant – Limit 1 per site every 60 months
D6040 Surgical placement: eposteal implant – Limit 1 per site every 60 months
D6050 Surgical placement: transosteal implant – Limit 1 per site every 60 months
D6055 Connecting bar – implant or abutment supported – Limit 1 every 60 months
D6056 Prefabricated abutment - includes modification and placement – Limit 1 every 60 months
D6057 Custom fabricated abutment - includes modification and placement – Limit 1 every 60 months
D6058 Abutment supported porcelain ceramic crown – Limit 1 every 60 months
D6059 Abutment supported porcelain fused to metal crown - high noble metal - Limit 1 every 60 months
D6060 Abutment supported porcelain fused to metal crown - predominately base metal - Limit 1 every 60 months
D6061 Abutment supported porcelain fused to metal crown - noble metal - Limit 1 every 60 months
D6062 Abutment supported cast metal crown - high noble metal - Limit 1 every 60 months
D6063 Abutment supported cast metal crown - predominately base metal – Limit 1 every 60 months
D6064 Abutment supported cast noble metal crown - noble metal – Limit 1 every 60 months
D6065 Implant supported porcelain/ceramic crown – Limit 1 every 60 months
D6066 Implant supported crown porcelain fused to high noble alloys – Limit 1 every 60 months
D6067 Implant supported crown - high noble alloys – Limit 1 every 60 months
D6068 Abutment supported retainer for porcelain/ceramic FPD – Limit 1 every 60 months
D6069 Abutment supported retainer for porcelain fused to metal FPD - high noble metal – Limit 1 every 60 months
D6070 Abutment supported retainer for porcelain fused to metal FPD - predominately base metal – Limit 1 every 60 months
D6071 Abutment supported retainer for porcelain fused to metal FPD - noble metal – Limit 1 every 60 months

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6072 Abutment supported retainer for cast metal FPD - high noble metal – Limit 1 every 60 months
D6073 Abutment supported retainer for cast metal FPD - predominately base metal - Limit 1 every 60 months
D6074 Abutment supported retainer for cast metal FPD - noble metal - Limit 1 every 60 months
D6075 Implant supported retainer for ceramic FPD – Limit 1 every 60 months
D6076 Implant supported retainer for FPD porcelain fused to high noble alloys - Limit 1 every 60 months
D6077 Implant supported retainer for metal FPD - high noble alloys – Limit 1 every 60 months
D6080 Implant Maintenance Procedures – Limit 1 every 60 months
D6082 Implant supported crown – porcelain fused to predominantly base alloys - Limit 1 every 60 months
D6083 Implant supported crown – porcelain fused to noble alloys - Limit 1 every 60 months
D6084 Implant supported crown – porcelain fused to titanium and titanium alloys - Limit 1 every 60 months
D6086 Implant supported crown – predominantly base alloys - Limit 1 every 60 months
D6087 Implant supported crown – noble alloys - Limit 1 every 60 months
D6088 Implant supported crown – titanium and titanium alloys - Limit 1 every 60 months
D6090 Repair Implant Prosthesis – Limit 1 every 60 months
D6091 Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment – Limit 1 every 60 months
D6092 Recement or re-bond implant/abutment supported crown - Limit 1 every 60 months
D6093 Recement or re-bond implant/abutment supported fixed partial denture – Limit 1 every 60 months
D6094 Abutment supported crown - titanium and titanium alloys - Limit 1 every 60 months
D6095 Repair Implant Abutment – Limit 1 every 60 months
D6097 Abutment supported crown – porcelain fused to titanium and titanium alloys - Limit 1 every 60 months
D6098 Implant supported retainer – porcelain fused to predominantly base alloys - Limit 1 every 60 months
D6099 Implant supported retainer for FPD – porcelain fused to noble alloys - Limit 1 every 60 months
D6100 Surgical removal of implant body – Limit once per implant location
D6101 Debridement of a peri-implant defect and surface cleaning of exposed implant surfaces, including flap entry and closure – Limit 1 per lifetime
D6102 Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and; includes surface cleaning of the exposed implant surfaces, including flap entry and closure – Limit 1 per lifetime
D6103 Bone graft for repair of peri-implant defect – does not include flap entry and closure - Limit 1 every 36 months
D6104 Bone graft at time of implant placement - Limit 1 every 36 months
D6105 Removal of implant body not requiring bone removal nor flap elevation - Limit once per implant location
D6106 Guided tissue regeneration – resorbable barrier, per implant - Limit 1 every 36 months
D6107 Guided tissue regeneration – non-resorbable barrier, per implant - Limit 1 every 36 months
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary - Limit 1 every 60 months
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular - Limit 1 every 60 months
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary - Limit 1 every 60 months
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular - Limit 1 every 60 months
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary - Limit 1 every 60 months
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular - Limit 1 every 60 months
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary - Limit 1 every 60 months
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular - Limit 1 every 60 months
D6120 Implant supported retainer – porcelain fused to titanium and titanium alloys - Limit 1 every 60 months
D6121 Implant supported retainer for metal FPD – predominantly base alloys - Limit 1 every 60 months
D6122 Implant supported retainer for metal FPD – noble alloys - Limit 1 every 60 months
D6123 Implant supported retainer for metal FPD – titanium and titanium alloys - Limit 1 every 60 months
D6190 Radiographic/surgical implant index, by report – Limit 1 every 60 months

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6191 Semi-precision abutment – placement – Limit 1 every 60 months
D6192 Semi-precision attachment – placement – Limit 1 every 60 months
D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys - Limit 1 every 60 months
D6195 Abutment supported retainer – porcelain fused to titanium and titanium alloys - Limit 1 every 60 months
D6205 Pontic – indirect resin based composite – Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6210 Pontic - cast high noble metal - Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6211 Pontic - cast predominately base metal - Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6212 Pontic - cast noble metal - Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6214 Pontic - titanium and titanium alloys - Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6240 Pontic - porcelain fused to high noble metal - Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6241 Pontic - porcelain fused to predominately base metal - Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6242 Pontic - porcelain fused to noble metal - Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6243 Pontic – porcelain fused to titanium and titanium alloys - Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6245 Pontic - porcelain/ceramic - Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6250 Pontic – resin with high noble metal – Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6251 Pontic - resin with predominantly base metal – Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6252 Pontic - resin with noble metal - Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6545 Retainer - cast metal for resin bonded fixed prosthesis - Limit 1 every 60 months, including all other crowns, bridges, prosthetics
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis - Limit 1 every 60 months, including all other crowns, bridges, prosthetics - **An alternate benefit will be provided**
D6549 Resin retainer - for resin bonded fixed prosthesis - Limit 1 every 60 months
D6600 Retainer inlay - porcelain/ceramic - 2 surfaces - Limit 1 every 60 months - **An alternate benefit will be provided**
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces - Limit 1 every 60 months - **An alternate benefit will be provided**
D6602 Retainer inlay-cast high noble metal, 2 surfaces – Limit 1 every 60 months
D6603 Retainer inlay-cast high noble metal, 3 + surfaces – Limit 1 every 60 months
D6604 Retainer inlay - cast predominantly base metal, two surfaces - Limit 1 every 60 months
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces - Limit 1 every 60 months
D6606 Retainer inlay - cast noble metal, 2 surfaces – Limit 1 every 60 months
D6607 Retainer inlay - cast noble metal, 3 + surfaces – Limit 1 every 60 months
D6608 Retainer onlay - porcelain/ceramic, 2 or more surfaces - Limit 1 every 60 months - **An alternate benefit will be provided**
D6609 Retainer onlay - porcelain/ceramic, 3 or more surfaces - Limit 1 every 60 months - **An alternate benefit will be provided**
D6610 Retainer onlay - cast high noble metal, 2 surfaces – Limit 1 every 60 months
D6611 Retainer onlay - cast high noble metal, 3 + surfaces – Limit 1 every 60 months
D6612 Retainer onlay - cast predominantly base metal, 2 + surfaces – Limit 1 every 60 months
D6613 Retainer onlay - cast predominantly base metal, 3 + surfaces – Limit 1 every 60 months
D6614 Retainer onlay - cast noble metal, 2 surfaces – Limit 1 every 60 months
D6615 Retainer onlay - cast noble metal, 3 + surfaces – Limit 1 every 60 months
D6624 Retainer inlay – titanium – Limit 1 every 60 months
D6634 Retainer onlay - cast titanium metal – Limit 1 every 60 months
D6710 Retainer crown - indirect resin based composite - Limit 1 every 60 months
D6720 Retainer crown - resin with high noble metal - Limit 1 every 60 months
D6721 Retainer crown - resin with predominantly base metal - Limit 1 every 60 months

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6722 Retainer crown - resin with noble metal – Limit 1 every 60 months
D6740 Retainer crown - porcelain/ceramic – Limit 1 every 60 months
D6750 Retainer crown - porcelain fused to high noble metal - Limit 1 every 60 months
D6751 Retainer crown - porcelain fused to predominately base metal – Limit 1 every 60 months
D6752 Retainer crown - porcelain fused to noble metal - Limit 1 every 60 months
D6753 Retainer crown – porcelain fused to titanium and titanium alloys - Limit 1 every 60 months
D6780 Retainer crown - 3/4 cast high noble metal - Limit 1 every 60 months
D6781 Retainer crown - 3/4 cast predominately base metal - Limit 1 every 60 months
D6782 Retainer crown - 3/4 cast noble metal – Limit 1 every 60 months
D6783 Retainer crown - 3/4 porcelain/ceramic – Limit 1 every 60 months
D6784 Retainer crown ¾ – titanium and titanium alloys - Limit 1 every 60 months
D6790 Retainer crown - full cast high noble metal - Limit 1 every 60 months
D6791 Retainer crown - full cast predominately base metal - Limit 1 every 60 months
D6792 Retainer crown - full cast noble metal - Limit 1 every 60 months
D6794 Retainer crown - titanium and titanium alloys - Limit 1 every 60 months
D7340 Vestibuloplasty - Ridge extension (secondary epithelialization)
D7350 Vestibuloplasty - Ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
D7994 Surgical placement zygomatic implant – Limit 1 per tooth every 60 months
D9932 Cleaning and inspection of removable complete denture maxillary – Limit 3 times per calendar year
D9933 Cleaning and inspection of removable complete denture mandibular – Limit 3 times per calendar year
D9934 Cleaning and inspection of removable partial denture maxillary – Limit 3 times per calendar year
D9935 Cleaning and inspection of removable partial denture mandibular – Limit 3 times per calendar year

Class C Major Notes:

- All major restorative and prosthodontic services (i.e., crown, bridges, implants and dentures) are combined under one replacement limitation under the plan. Benefits for major restorative and prosthodontic services are combined and limited to one every 60 months per tooth or arch depending on the service. For example, if benefits for a removable partial denture are paid, this includes benefits to replace all missing teeth in the arch. No additional benefits for the arch would be considered until the 60 month replacement limit was met.
- When dental services that are subject to a frequency limitation were performed prior to your effective date of coverage the date of the prior service may be counted toward the time, frequency limitations and/or replacement limitations under this dental insurance. (For example, even if a crown, partial bridge, etc. was not placed while covered under BCBS FEP Dental, or paid by BCBS FEP Dental, the frequency limitations may apply.)

Periodontal Services:

- Full mouth diagnostic quality radiographic images and/or a panoramic radiographic image including bitewings radiographs; labeled and dated (within 12 months of submitted procedure)
- Periodontal Charting: 6-point periodontal pocket depth charting as described by the ADA and AAP labeled and dated (within 12 months of submitted procedure)
- Teeth to be treated must demonstrate at least 5-millimeter pocket depths
- Gingivectomy or gingivoplasty performed in conjunction with restorative services are considered to be inclusive of the restoration and will not be reimbursed.
- Gingival flap procedure must be a surface adjacent to an edentulous/terminal tooth area
- Clinical crown lengthening: Prior to final restoration of a tooth, a minimum of six weeks must be allowed for healing of bone and soft tissue following clinical crown lengthening

Services Not Covered

Refer to Section 7 for a list of general exclusions

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 for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- There is no waiting period under the BCBS FEP Dental Plan.
- We pay 50% of the plan allowance up to the lifetime maximum. The lifetime maximum for orthodontic services depends on the option in which you enroll and if you choose to receive services from a network provider. If you are covered by High Option, the lifetime maximum is up to $3,500. However, the maximum amount allowed (see page 11) depends on the participation status of the provider. If you are enrolled in Standard Option, the lifetime maximum for services rendered by an in-network provider is up to $2,500 and for services rendered by an out-of-network provider the lifetime maximum is up to $1,250. Your out-of-pocket expenses will be higher when using an out-of-network provider.
- In no instance will BCBS FEP Dental allow more than $2,500 under Standard Option.
- The benefit for the initial placement will not exceed 25% of the lifetime maximum benefit amount for the appliance. All subsequent payments will be made in equal installments pro-rated over the balance of a maximum period of 29 months. If your coverage terminates, all orthodontia benefit payments will end.
- Covered services are limited to the maximum allowable charge as determined by us and are subject to alternative benefit, coinsurance, maximum benefit limits, and the other limitations described in this plan document.
- We cover traditional orthodontic treatment (braces) as well as Invisalign®. To determine what is most cost effective, we recommend a pretreatment estimate.
- The allowed amount is based on the orthodontic treatment and does not guarantee that the full lifetime maximum will be paid out on a single treatment. If the ortho treatment is already in progress at the time of eligibility, the orthodontic benefit will be prorated based on the number of months remaining in the treatment plan up to the lifetime maximum.
- Coverage for pre-treatment orthodontic exam and x-rays may be allowed if completed more than 3 months from initial appliance placement.
- Applying the Limited Access provision will not result in additional payment under the High Option orthodontic plan.
- Any dental service or treatment not listed as a covered service is not eligible for benefits.
- This requirement includes assumption of payments for covered orthodontia services up to the FEDVIP policy limits, and full payment where applicable up to the terms of FEDVIP policy for covered services completed (but not initiated) in the 2022 plan year such as crowns and implants.

You Pay:

High Option

- **In-Network:** 50% of the plan allowance up to the lifetime maximum. You are responsible for all charges that exceed the lifetime maximum.
- **Out-of-Network:** 50% of the plan allowance up to the lifetime maximum and any difference between our allowance and the billed amount.

Standard Option

- **In-Network:** 50% of the plan allowance up to the lifetime maximum. You are responsible for all charges that exceed the lifetime maximum.

- **Out-of-Network:** 50% of the plan allowance up to the lifetime maximum and any difference between our allowance and the billed amount.

Orthodontic Services

D0340 2D cephalometric radiographic image – acquisition, measurement and analysis - may be allowed if completed more than 3 months prior to the start of orthodontic treatment

D0350 2D oral/facial photographic image obtained intra-orally or extra-orally – may be allowed if completed more than 3 months prior to the start of orthodontic treatment

D0470 Diagnostic casts – may be allowed if completed more than 3 months prior to the start of orthodontic treatment

D0801 3D dental surface scan – direct - may be allowed if completed more than 3 months prior to the start of orthodontic treatment

D0802 3D dental surface scan – indirect - may be allowed if completed more than 3 months prior to the start of orthodontic treatment

D7283 Placement of device to facilitate eruption of impacted tooth, covered 1 per lifetime

D8010 Limited orthodontic treatment of the primary dentition

D8020 Limited orthodontic treatment of the transitional dentition

D8030 Limited orthodontic treatment of the adolescent dentition

D8040 Limited orthodontic treatment of the adult dentition

D8070 Comprehensive orthodontic treatment of the transitional dentition

D8080 Comprehensive orthodontic treatment of the adolescent dentition

D8090 Comprehensive orthodontic treatment of the adult dentition

D8210 Removable appliance therapy

D8220 Fixed appliance therapy

D8660 Pre-orthodontic treatment examination to monitor growth and development

D8670 Periodic orthodontic treatment visit (as part of contract) – monthly payments automatically made if orthodontic treatment plan is in place

D8681 Removable orthodontic retainer adjustment

Services Not Covered

Refer to Section 7 for a list of general exclusions:

- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliances
- 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.
- Over-the-counter or mail order Orthodontic treatments

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 for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is $0, if you use an in-network provider.
- If you elect to use an out-of-network provider, the Standard Option has a $75 deductible per person; High Option has a $50 deductible per person. Neither Option contains a family deductible, each enrolled covered person must satisfy their own deductible.
- There is no High Option Annual Benefit Maximum for non-orthodontic in-network services, and $3,000 for out-of-network services.
- The Standard Option Annual Benefit Maximum for non-orthodontic services is $1,500 for in-network services and $750 for out-of-network services. In no instance will BCBS FEP Dental allow more than $1,500 in combined benefits under Standard Option in any plan year.
- All services requiring more than one visit are payable once all visits are completed.
- The following list is an all-inclusive list of covered services. BCBS FEP Dental will provide benefits for these services, subject to the exclusions and limitations shown in this section and Section 7.

You Pay:

High Option

- **In-Network:** No deductible; you pay 30% of the plan allowance for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** $50 deductible; you pay 40% of the plan allowance for covered services as defined by the plan subject to plan maximums and any difference between our allowance and the billed amount.

Standard Option

- **In-Network:** No deductible; you pay 45% of the plan allowance for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** $75 deductible; you pay 60% of the plan allowance for covered services as defined by the plan, subject to plan maximums and any difference between our allowance and the billed amount.

Anesthesia Services

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia

D9222 Deep sedation/general anesthesia – first 15 minutes. Up to 8 units of anesthesia (D9222 & D9223).

D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment. Up to 8 units of anesthesia (D9222 & D9223).

Intravenous Sedation

D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment. Up to 8 units of anesthesia (D9239

D9239 Intravenous moderate (conscious) sedation/anesthesia – first 15 minutes. Up to 8 units of anesthesia (D9239 & D9243).

Medications
D9610 Therapeutic parenteral drug, single administration
D9612 Therapeutic parenteral drugs, two or more administrations, different medications
D9613 Infiltration of sustained release therapeutic drug, per quadrant
Post-Surgical Services
D9930 Treatment of complications (post-surgical) unusual circumstances, by report
Miscellaneous Services
D9941 Fabrication of athletic mouthguard –Limit 1 every 12 months
D9943 Occlusal guard adjustment - Limit 1 every 6 months for patients 13 and older
D9944 Occlusal guard – hard appliance, full arch – Limit 1 every 12 months for patients 13 and older
D9945 Occlusal guard – soft appliance, full arch – Limit 1 every 12 months for patients 13 and older
D9946 Occlusal guard – hard appliance, partial arch – Limit 1 every 12 months for patients 13 and older
D9974 Internal bleaching - per tooth
D9999 Unspecified Adjunctive procedure, by report

General Services Notes:

- Deep sedation/general anesthesia and intravenous sedation are covered when provided in conjunction with covered surgical procedures. The services must be rendered by a dentist licensed and approved to provide anesthesia in the state where rendered.
- Deep sedation/general anesthesia and intravenous sedation are covered when determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable conditions.
- In order for deep sedation/general anesthesia and intravenous conscious sedation to be covered, submission must include the procedure for which it was necessary.

Services Not Covered

Refer to Section 7 for a list of general exclusions.

Section 6 International Services and Supplies

International Claims Payment

We will pay benefits, subject to plan provisions, in an amount equal to the covered percentage for the charges incurred by you. You are responsible for paying the dentist and for submitting your claims to BCBS FEP Dental. We will reimburse you in US dollars based on the OANDA currency conversion rate.

Finding an International Provider

You may visit any dentist and you will receive in-network benefits for any covered benefits received internationally. However, if you receive care from a dentist that participates in our international dental program you will benefit by receiving our negotiated discounted provider rates. Our international dental program includes English-speaking dentists in approximately 100 countries worldwide. Customer service is available 24/7 to assist in making an appointment.

For help in locating an in-network provider, you may call 24 hours a day (outbound calling code for the country you are calling from) plus 353-94-9372257. If calling from Ireland, press 0-94-9372257.

Customer service (in the U.S.) 1-855-504-2583

Customer service (international) call collect 651-994-2583

Filing International Claims

You are responsible for paying the dentist and submitting the claims to BCBS FEP Dental for reimbursement. Mail the completed claim form and receipt to:

BCBS FEP Dental Claims
P.O. Box 75
Minneapolis, MN 55440-0075

International Rates

There is one international region. Please see the rate table for the actual premium amount.

Section 7 General Exclusions – Things We Do Not 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:

• 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 provision of any law or regulation or any government 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, VA hospital or similar person or group;

• Services and treatment performed prior to your effective date of coverage;

• Services and treatment incurred after the termination date of your coverage unless otherwise indicated;

• Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.

• Services and treatment resulting from your failure to comply with professionally prescribed treatment;

• Any charges for failure to keep a scheduled appointment;

• Any services that are considered 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;

• Those services submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;

• Those services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;

• Those services for which the member would have no obligation to pay in the absence of this or any similar coverage;

• Those services which are for specialized procedures and techniques;

• Those services performed by a dentist who is compensated by a facility for similar covered services performed for members;

• Duplicate, provisional and temporary devices, appliances, and services;

• Plaque control programs, oral hygiene instruction, and dietary instructions;

• 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;

• Gold foil restorations;

• Charges for sterilizing;

• Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;

• Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;

• Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);

• Charges by the provider for completing dental forms;

• Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;

• Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;

• Cone Beam Imaging and Cone Beam MRI procedures;

• Sealants for teeth other than permanent molars are not covered. Initial placement of sealants are covered on unrestored 1st molars between ages of 6 through 9 and for 2nd permanent molars between ages 12 through 15. Repair /replacement are covered up to age 22 once every 24 months;

• Precision attachments, personalization, precious metal bases and other specialized techniques;

• Replacement of dentures that have been lost, stolen or misplaced;

• Repair of damaged orthodontic appliances;

• Replacement of lost or missing appliances;

• External bleaching;

• Nitrous oxide;

• Oral sedation;

• Topical medicament center;

• Bone grafts when done in connection with extractions, apicoetomies or non-covered/non-eligible implants;

• Interim therapeutic restoration - primary;

• Veneers;

• Blood glucose level test - in-office using a glucose meter;

• Temporomandibular joint dysfunction – non-invasive physical therapies; and

• Duplicate/copy patient's records

• When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other service) as determined by BCBS FEP Dental.

• When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by this plan.

• Incomplete Endodontic Therapy, inoperable, unrestorable or fractured tooth is not a covered service.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

To avoid delay in the payment of your dental claims, please have your dental provider submit your claims directly to your FEHB plan (Should you be enrolled), then to BCBS FEP Dental. Pre-treatment estimates and diagnostic quality preoperative periapical radiographs and/or panoramic images can be submitted directly to BCBS FEP Dental (exception: If accidental injury occurs, pre-treatment estimates should be submitted to your FEHB plan).

If you need to send in a paper claim you may download a claim form from BCBS FEP Dental's website, www.bcbsfepdental.com.

Mail completed claim form to:

BCBS FEP Dental Claims
P.O. Box 75
Minneapolis, MN 55440-0075

Deadline for Filing Your Claim

You must submit your claim within 24 months from the date service was rendered.

Disputed Claims Process

Step Description

1. Ask us in writing to reconsider our initial decision. You must include any pertinent information omitted from the initial claim filing and send your additional proof to us within 60 days from the date of receipt of our decision.

2. You may mail your request for reconsideration to:

BCBS FEP Dental Claims Appeals
P.O. Box 551
Minneapolis, MN 55440-0551

Or go to www.bcbsfepdental.com and select "contact us"

We will review your request and provide you with a written or electronic explanation of benefit determination within 30 days of the receipt of your request.

3. If you disagree with the decision regarding your request for reconsideration, you may request a second review of the denial. You must submit your request to us in writing to the address shown above along with any additional information you or your dentist can provide to substantiate your claim so that we can reconsider our decision. Failure to do so will disqualify the appeal of your claim.

4. If you do not agree with our final decision, under certain circumstances you may request an independent third party, mutually agreed upon by BCBS FEP Dental and OPM, review the decision. To qualify for this independent third-party review, the reason for denial must be based on our determination that the rationale for the procedure did not meet our dental necessity criteria or our administration of the plans Alternate Benefit provision, for example, a bridge being given an alternate benefit of a partial denture.

The decision of the independent third party is binding and is the final review of your claim.

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

Members may appeal any claims decision by submitting a written notice via U.S. Mail or email.

Section 9 Definitions of Terms We Use in This Brochure

Alternative Benefit	If we determine a service less costly than the one performed by your dentist could have been performed by your dentist, we will pay benefits based upon the less costly services. See Section 3, How You Get Care.
Annual Benefit Maximum	The maximum annual benefit that you can receive per person.
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 brochure.
Calendar Year	From January 1, 2023 through December 31, 2023. Also referred to as the plan year.
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.
Coinsurance	Coinsurance is the stated percentage of covered expenses you must pay.
Copay/Copayment	A copayment is a fixed amount of money you pay the provider when you receive the service.
Cosmetic Procedure	A cosmetic procedure is any procedure or portion of a procedure performed primarily to improve physical appearance or is performed for psychological purposes.
Covered Services	Covered services shall include only those services specifically listed in Section 5 Dental Services and Supplies. 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.
Date of Service	The calendar date on which you visit the dentist's office and services are rendered.
Enrollee	The Federal employee, annuitant, or TRICARE-eligible individual enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Generally Accepted Dental Protocols	Dental Necessity means that a dental service or treatment is performed in accordance with generally accepted dental standards, as determined from multiple sources including but not limited to relevant clinical dental research from various research organizations including dental schools, current recognized dental school standard of care curriculums and organized dental groups including the American Dental Association, which is necessary to treat decay, disease or injury of teeth, or essential for the care of teeth and supporting tissues of the teeth.
In-Progress Treatment	Dental services that initiated in 2022 that will be completed in 2023.
Incur/Incurred	A covered service is deemed incurred on the date care, treatment or service is received.

Maximum Allowed Amount	The amount we use to determine our payment for services. If services are provided by an in-network dentist, the maximum allowable amount is based on the discounted fee they accept as payment in full for the procedure or procedures. If services are provided by an out-of-network dentist, the maximum allowed amount is based on BCBS FEP Dental's determination of charges for the procedure or procedures.
Network Allowance	Network Allowance means the allowance per procedure that BCBS FEP Dental has negotiated with the provider, and they have agreed to accept as payment in full for their services.
Plan	BCBS FEP Dental
Sponsor	Generally, a sponsor means the individual who is eligible for medical or dental benefits under 10 U.S.C. chapter 55 based on their direct affiliation with the uniformed services (including military members of the National Guard and Reserves).
TEI certifying family member	Under circumstances where a sponsor is not an enrollee, a TEI family member may accept responsibility to self-certify as an enrollee and enroll TEI family members
TRICARE-eligible individual (TEI) family member	TEI family members include a sponsor's spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in a sponsor's legal custody by a court. Children include legally adopted children, stepchildren, and pre- adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.
Waiting Period	The amount of time that you must be enrolled in this plan before you can receive Orthodontic services. Note, there are no waiting periods associated with BCBS FEP Dental.
We/Us	BCBS FEP Dental
You	Enrollee or eligible family member.

Discounts and Features

Blue365® Discounts

Great news! As a member of BCBS FEP Dental^{SM}, you have access to exclusive health and wellness discounts through the Blue365® Program including some of the industry's best discounts:

Low-cost gym memberships - Discounts on low cost monthly gym membership with access to over 10,000 locations through vendors such as Fitness your Way® and Gympass®

Wearable devices - Discounts on wearable devices such as Fitbit®, Garmin® and more

Eyewear and Vision Care Discounts - Members receive discounts on additional pairs of eyewear when using the Davis Vision® network providers

Gym shoes and athletic apparel - Discounts on Reebok® and Skechers®

Dieting, Healthy Eating, and Organic Food Delivery - Discounts on Jenny Craig®, Nutrisystem®, Farmbox®, and Sun Basket® food delivery

Travel Discounts on Hotels, Rental Cars, and Vacation Packages - Discounts on Hotels.com™, Walt Disney World®, and rental cars from Avis® and Budget®

1. Visit www.blue365deals.com/fep and click on "Register"
2. Enter your personal information (First Name, Last Name, Email, etc.)
3. For the Member ID Prefix, please use the first three characters of your member ID card
4. Read and accept the terms, and click "Register" to start saving!
5. Visit www.blue365deals.com/fep to register and start saving today.

Features

AskBlue BCBS FEP Dental Plan Finder

Need help choosing between High Option and Standard Option? AskBlue makes it easy. In just 10 minutes, you can answer some simple questions and get recommended a plan based on your needs. Try AskBlue by visiting askblue.bcbsfepdental.com.

Member Portal

Visit our member portal at www.bcbsfepdental.com to check the status of your claims, request claim forms, request a duplicate or replacement ID card, and track how you use your benefits. Additional features include:

- Download a Dental Brochure
- Compare Benefit Plans
- Read Oral health and wellness articles
- Learn How to Enroll

And much more

BCBS FEP Dental Mobile Application

Blue Cross and Blue Shield FEP Dental's mobile application is available for download for both iOS and Android mobile phones. The application provides members with 24/7 access to helpful features, tools and information related to Blue Cross and Blue Shield FEP Dental benefits. Members can log in with their username and password to access personal dental information such as benefits, out-of-pocket costs, and wellness information. They can also view claims and approval status, view/share Explanations of Benefits (EOBs), view/share member ID cards, and locate in-network providers.

Social Media

Follow us @bcbsfepdental on Facebook and Twitter for the latest information happening at BCBS FEP Dental.

Summary of Benefits

- **Do not rely on this chart alone.** This page summarizes your portion of the expenses we cover; please review the individual sections of this brochure, for more detail.
- 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.
- Out-of-Network services under Classes A, B and C are subject to a $50 deductible per person under High Option and a deductible of $75 for Standard Option per person per calendar year.
- For children age 13 and under, you pay $0 for In-Network Class B, and Class C covered services as defined by the plan subject to plan maximums.

High Option Benefits	You Pay	
	In-Network	**Out-of-Network**
Class A (Basic) Services – preventive and diagnostic Class A, B, and C Services are subject to an unlimited annual maximum benefit amount for in-network services and $3,000 for out-of-network services.	0%	10%
Class B (Intermediate) Services – includes minor restorative services Class A, B, and C Services are subject to an unlimited annual maximum benefit amount for in-network services and $3,000 for out-of-network services.	30%	40%
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services Class A, B, and C Services are subject to an unlimited annual maximum benefit amount for in-network services and $3,000 for out-of-network services.	50%	60%
Class D Services – orthodontic up to $3,500 Lifetime Maximum	50%	50%

Standard Option Benefits	You Pay	
	In-Network	**Out-of-Network**
Class A (Basic) Services – preventive and diagnostic Class A, B, and C Services are subject to a $1,500 annual maximum benefit for the in-network benefits and $750 for the out-of-network benefits	0%	40%
Class B (Intermediate) Services – includes minor restorative services Class A, B, and C Services are subject to a $1,500 annual maximum benefit for the in-network benefits and $750 for the out-of-network benefits	45%	60%
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services Class A, B, and C Services are subject to a $1,500 annual maximum benefit for the in-network benefits and $750 for the out-of-network benefits	65%	80%

- continued on next page

Standard Option Benefits (cont.)	You Pay	
	In-Network	Out-of-Network
Class D Services – orthodontic $2,500 Lifetime Maximum for in-network, or $1,250 Lifetime Maximum for out-of-network	50%	50%

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, BCBS FEP Dental, 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 explanation 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 1-855-504-2583 and explain the situation, you will be required to state your complaint in writing to us.

• Do not maintain as a family member on your policy:

  • Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

  • Federal civilian Eligibles: Your child over age 22 (unless they are disabled and incapable of self- support

  • TRICARE Eligibles do not maintain as a family member on your policy:

    - Your child over age 21 if they are not enrolled in school (unless they are disabled and incapable of self-support)

    - Your child over age 23 if they are enrolled in school (unless they are disabled and incapable of self-support)

If you have any questions about the eligibility of a dependent, please contact BENEFEDS.

Be sure to review Section 1, Eligibility, of this brochure prior to submitting your enrollment or obtaining benefits.

Fraud or intentional misrepresentation of material fact is prohibited under the plan. You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the plan, or enroll in the plan when you are no longer eligible.

Notes

Notes

Notes

Rate Information

How to find your rate: In the first chart below, look up your state or zip code to determine your rating area. In the second chart on the following page match your Rating Area to the enrollment type and plan option.

Premium Rating Areas by State/Zip Code (first three digits)

State	Zip	Rating Region	State	Zip	Rating Region	State	Zip	Rating Region
AK	Entire State	5	LA	Entire State	1	NY	Rest of State	2
AL	Entire State	1	MA	010-011, 013-027,055	5	OH	Entire State	1
AR	Entire State	2	MA	Rest of State	3	OK	Entire State	1
AZ	855,859-860,863-865	2	MD	205-212, 214,216-217	3	OR	970-973	4
AZ	850-853	3	MD	Rest of State	2	OR	Rest of State	2
AZ	Rest of State	1	ME	039-042	5	PA	180-181, 183	4
CA	900-908, 910-928,930-931, 933-935	4	ME	Rest of State	2	PA	189-196	2
CA	939-952,954,956-959	5	MI	480-485	2	PA	172-174	3
CA	Rest of State	2	MI	Rest of State	1	PA	Rest of State	1
CO	Entire State	4	MN	550-551, 553-555,536	4	PR	Entire Area	1
CT	060-063	5	MN	Rest of State	3	RI	Entire State	5
CT	Rest of State	4	MO	726	2	SC	Entire State	2
DC	Entire Area	3	MO	Rest of State	1	SD	Entire State	1
DE	Entire State	2	MS	Entire State	1	TN	Entire State	1
FL	330-334, 349	2	MT	Entire State	1	TX	Entire State	1
FL	Rest of State	1	NC	270-274, 278,280-282, 284-289	2	UT	Entire State	2
GA	Entire State	1	NC	275-277, 283	3	VA	201, 205, 220-227	3
GU	Entire Area	1	NC	Rest of State	1	VA	Rest of State	1
HI	Entire State	3	ND	Entire State	5	VI	Entire Area	1
IA	500-514,516,520-528	3	NE	Entire State	2	VT	Entire State	5
IA	Rest of State	2	NH	030-033, 038	5	WA	980-985	5
ID	Entire State	4	NH	Rest of State	3	WA	Rest of State	4
IL	600-609, 613	2	NJ	070-079, 085-089	4	WI	540	4
IL	612	3	NJ	Rest of State	2	WI	Rest of State	3
IL	Rest of State	1	NM	Entire State	1	WV	254	3
IN	463-464	2	NV	897	5	WV	Rest of State	1
IN	Rest of State	1	NV	Rest of State	2	WY	834	4
KS	664-665, 667-679	2	NY	120-123, 128	3	WY	Rest of State	2
KS	Rest of State	1	NY	063	5	INTL	International	1
KY	Entire State	1	NY	005, 100-119, 124-126	4			

Rates

Rating Area	High - Bi-Weekly			High - Monthly		
	Self Only	Self Plus One	Self and Family	Self Only	Self Plus One	Self and Family
1	$18.02	$36.05	$54.07	$39.04	$78.11	$117.15
2	$20.19	$40.38	$60.57	$43.75	$87.49	$131.24
3	$21.98	$43.97	$65.95	$47.62	$95.27	$142.89
4	$23.81	$47.62	$71.43	$51.59	$103.18	$154.77
5	$26.65	$53.29	$79.94	$57.74	$115.46	$173.20

Rating Area	Standard - Bi-Weekly			Standard - Monthly		
	Self Only	Self Plus One	Self and Family	Self Only	Self Plus One	Self and Family
1	$9.19	$18.38	$27.58	$19.91	$39.82	$59.76
2	$10.07	$20.15	$30.22	$21.82	$43.66	$65.48
3	$11.45	$22.89	$34.31	$24.81	$49.60	$74.34
4	$12.36	$24.70	$37.03	$26.78	$53.52	$80.23
5	$13.65	$27.31	$40.96	$29.58	$59.17	$88.75