Blue Cross Blue Shield FEP Dental®

www.bcbsfepdental.com

1-855-504-BLUE (2583)

BlueCross BlueShield | FEP Dental®

2025

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 five 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-BLUE (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, 2025 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 dentists in your area. Contact us at 1-855-504-BLUE (2583) or TTY: 711 for the names of participating dentists or to request a Zip code-based dentist directory. Network dentists are listed on our website at www.bcbsfepdental.com/findadentist and on the BCBS FEP Dental mobile app. Our directory is updated weekly. You may also contact us at 1-855-504-BLUE (2583) for further assistance. Continued participation of any specific dentist cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not on a specific dentist's participation. When you phone for an appointment, please remember to verify that the dentist is currently in the BCBS FEP Dental network. If your dentist is not currently participating in the network, you can nominate them to join. Dentist nominations can be submitted online or via 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 dentist network.**

The network 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, contact us for assistance. Please be aware that the BCBS FEP Dental network may be different from your health plan's network.

This BCBS FEP Dental Plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program/Postal Health Benefits (PSHB) 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, visit our website at www.bcbsfepdental.com and link to the "Policies" at the bottom of the page. If you do not have access to the internet or would like further information, 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 2025

2025 Changes:

Changes to our Blue365® Program:

- We increased the discount vendors in our Blue365 Program. Now there are over 100 different discounts in categories such as, fitness, healthy eyes and ears, home and family, nutrition, personal care, and travel. (See page 45)

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.gov. 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 2025 Open Season, your coverage will begin on January 1, 2025. Premium deductions will start with the first full pay period beginning on/after January 1, 2025. 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 11, 2024 through midnight EST December 9, 2024. 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.
Compliance with the American Dental Association (ADA)	FEDVIP abides by the Current Dental Terminology (CDT) codification system in accordance with standards set by the American Dental Association (ADA). *Current Dental Terminology (CDT)*, Copyright © American Dental Association. All rights reserved.

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, the Postal Service Health Benefits (PSHB), 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, PSHB Program, or a Health Insurance Marketplace (Exchange) plan is not required.

Temporary / Seasonal Employees

Certain temporary, intermittent, and seasonal Federal and U.S. Postal Service employees are now eligible to enroll in FEDVIP. To be eligible, these employees must be expected to work 130 hours per calendar month for at least 90 days. In addition, certain firefighters hired under a temporary appointment and intermittent emergency response personnel are eligible to enroll in FEDVIP. The employing agency must determine and notify these employees of their eligibility.

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/PSHB 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/PSHB 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/PSHB 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/PSHB 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)
- Temporary/seasonal employees who do not meet the 130 hours per calendar month for 90 days

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.gov) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (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 2025.

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.

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 11, 2024 through midnight EST December 9, 2024, Open Season. Coverage is effective January 1, 2025.

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;
- an employee returning to service following a break in service of at least 31 days; or
- 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.

Opportunities to Enroll or Change Enrollment

The following 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 (LWOP)
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.

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

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.

VA Exception for Cancellation

Generally, you may cancel your enrollment only during the annual open season. However, if you are a FEDVIP enrollee paying premiums on a **post-tax basis**, and you, your family member, or TEI family member becomes eligible for VA dental or vision benefits, then you **may** change your enrollment type or cancel your enrollment within 60 days of receiving notification of VA dental or vision eligibility. This 60-day period may fall outside of open season. VA dental or vision eligibility documentation must be submitted to OPM via the BENEFEDS mailbox (benefedsportal@opm.gov) within 60 days of notification to support the FEDVIP enrollment change or cancellation.

If you are a FEDVIP enrollee paying premiums on a **pre-tax basis,** and you, your family member, or TEI family member becomes eligible for VA dental or vision benefits, then you **may not** change or cancel your FEDVIP enrollment until the next open season.

FEDVIP enrollees can verify if they are paying their premiums on a pre- or post-tax basis by contacting BENEFEDS at 1-877-888-3337, TTY number 1-877-889-5680.

When Coverage Stops

Coverage ends for active and retired Federal employees, 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;
- the sponsor or primary enrollee leaves active duty

- you 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;
- you are making direct premium payments to BENEFEDS and you stop making the payments;
- you cancel the enrollment during open season.

Coverage for a family member ends when:

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

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

FSAFEDS/High Deductible Health Plans and FEDVIP

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

Please review IRS - Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans (https://www.irs.gov/forms-pubs/about-publication-969) for additional information about carryover and contribution amounts for the upcoming tax year. If you have an HCFSA or LEX HCFSA FSAFEDS account and you have not exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over a set maximum amount 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 31st. You must also actively re-enroll in a health care or limited expense account during the next open season to be carryover eligible. Your re-enrollment must meet the minimum contribution amount for the plan year. If you do not re-enroll, 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 permitted. This is known as the "Use-it-or-Lose-it" rule. Carefully consider the amount you will elect.

Current FSAFEDS participants must re-enroll to participate in the program next year. See https://www.fsafeds.gov 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 may use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB/PSHB and/or FEDVIP plans.

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 (ID) card which will serve as confirmation of your enrollment. Each contract holder will receive two BCBS FEP Dental ID cards. The ID cards will only have the contract holder's name on them. Since most FEHB/PSHB plans offer some level of dental benefits separate from your FEDVIP coverage, presenting both ID cards can ensure that you receive the maximum allowable benefit under each program along with accurate and timely claims processing.

Existing members who were previously issued ID cards will not receive new ID cards unless otherwise requested. You may order a replacement ID card via www.bcbsfepdental.com or by calling customer service at 1-855-504-BLUE (2583).

An ID card is neither a guarantee of benefits nor does your dentist need it to render dental services. Your dentist may call 1-855-504-BLUE (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 Dentists

Network dentist are listed on our website at www.bcbsfepdental.com/findadentistand on the BCBS FEP Dental mobile app. Our directory is updated weekly. You may also contact us at 1-855-504-BLUE (2583) for further assistance.

In-Network

BCBS FEP Dental negotiates rates with dentists to help reduce your costs. We refer to these dentists as in-network. If you use one of these dentists, benefits are paid at the in-network level. To find a dentist in your area go to www.bcbsfepdental.com/findadentist or contact customer service at 1-855-504-BLUE (2583).

Note: The BCBS FEP Dental dentist network may be different from the BCBS Federal Employee Program (FEP) medical network.

Before each appointment, verify the dentist is in-network at the service location.

Out-of-Network

You may obtain care from any licensed dentist. If the dentist you use is not part of our network, we will pay for their services based on an out-of-network benefit level and plan allowance, resulting in a lower annual maximum benefit. You are responsible for the difference between our payment and the amount billed. If you choose to go out of network, we will pay our portion to the contract holder directly.

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.

Pre-treatment Estimate

Pre-treatment estimates are not mandatory. However, we do recommend that your dentist submits a pre-treatment estimate if you are considering major or extensive dental care such as implant services and/or fixed partial dentures. Pre-treatment estimates should include a comprehensive treatment plan and necessary supporting documentation such as chart notes, radiographic images, and photos.

If more than on service can be used to treat a dental condition, benefits may be alternated to a less costly procedure that meets broadly accepted national standards of dental practice.

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 plan allowance is based on your current eligibility and benefits in effect at the time of the pre-treatment estimate. Submission of other claims or changes in eligibility or benefits may alter final payment. A pre-treatment estimate is not a guarantee of benefits.

Pre-treatment estimates are valid through the calendar year in which they are processed, or 12 months, subject to eligibility and plan limitations.

Submit pre-treatment estimates to BCBS FEP Dental at the address below. Do not send pre-treatment estimates to your medical plan.

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

Alternate Benefit

If more than one service or procedure can be used to treat the dental condition, we reserve the right to authorize an alternate, less costly covered service as deemed by a dental professional to be appropriate and to meet broadly accepted national standards of dental practice.

If you and your dentist choose the more expensive treatment instead of the alternate benefit, you are responsible for the additional charges beyond the plan allowance for the alternate service.

Example: If a dental professional determines an implant is not dentally necessary or a less expensive appropriate treatment is available, no benefits will be allowed for the individual implant or implant related procedures, and the allowance for the less expensive treatment may be approved.

Dental Review

Some dental services submitted on a claim may be reviewed for benefit determination and dental necessity. This review is conducted by licensed dental professionals who will review the clinical documentation and diagnostic images submitted by your treating dentist.

There may be situations resulting from the dental review where an alternate benefit is applied that meets broadly accepted national standards of dental practice. This review applies to procedures including but not limited to, onlays, crowns, buildups, bridges, implants, periodontal treatment, extractions and anesthesia.

FEHB/PSHB First Payor

It is important to know that, per FEDVIP requirements, the FEHB/PSHB plan will always be the first payor when you are also covered under BCBS FEP Dental. Therefore, always provide your dental office with both your FEHB/PSHB and BCBS FEP Dental ID cards at each appointment. Your dental office should submit your claim(s) to the FEHB/PSHB carrier first.

When you visit a provider who participates with both your FEHB/PSHB plan and your FEDVIP plan, the FEHB/PSHB plan will pay benefits first.

In these cases, the BCBS FEP Dental plan allowance will be the negotiated allowable charge between the plan and the dentist. You are responsible for the difference between the total FEHB/PSHB and BCBS FEP Dental payment and the plan allowance.

We are responsible for facilitating the process if the primary FEHB/PSHB payor is FEP medical.

If you are covered under the Blue Cross Blue Shield Service Benefit Plan Basic Option and BCBS FEP Dental, you are not responsible for the $30 co-pay (up to 2 evaluations per year). If your dentist collects the co-pay upfront, they are required to reimburse the co-pay in full once the claim has processed under BCBS FEP Dental.

Please see the following examples that assume all deductibles have been met and annual maximums have not been reached.

Example 1: High Option coverage (In-Network dentist)
Class B dentist fee: $108.00
FEHB/PSHB payment: $16.00
BCBS FEP Dental plan allowance: $60.00
BCBS FEP Dental payment: $42.00 ($60.00 at 70%)
Member's responsibility*: $2.00 ($60-$16-$42)

Example 2: High Option coverage (Out-of-Network dentist).
Class B dentist fee: $108.00
FEHB/PSHB payment: $16.00
BCBS FEP Dental payment: $64.80 ($108.00 at 60%)
Member's responsibility*: $27.20 ($108-$16-$64.80)

*Assumes dentist charge is within the plan allowance

Coordination of Benefits (COB)

If you are covered under a non-FEHB/non-PSHB plan, your BCBS FEP Dental benefits will be coordinated using traditional COB provisions for determining payment. We will coordinate benefit payments with the payment of benefits under other group health benefits coverage (non-FEHB/non-PSHB) you may have and the payment of dental costs under no-fault insurance that pays benefits without regard to fault. Please see the following examples that assume all deductibles have been met and annual maximums have not been reached.

Example 1: High Option coverage (In-Network dentist)
Class B dentist fee: $121.00
FEHB/PSHB payment: $60.50
BCBS FEP Dental plan allowance: $73.00
BCBS FEP Dental payment: $51.10 ($73.00 at 70%)
Payment by BCBS FEP Dental: $12.50
Member's responsibility*: $0.00 ($73-$60.50-$12.50)

Example 2: High Option coverage (Out-of-Network dentist)
Class B dentist fee: $121.00
FEHB/PSHB payment: $96.80
BCBS FEP Dental payment: $72.60 ($121.00 at 60%)
Payment by BCBS FEP Dental: $24.20 ($121-$96.80)
Member's responsibility*: $27.20 ($121-$96.80-$24.20)

*Assumes dentist charge is within the plan allowance

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 at www.BENEFEDS.gov or by phone at 877-888-FEDS (3337). 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 an area with limited access to a network dentist and you receive covered services from an out-of-network dentist, we will pay the same benefit level as if you utilized the services of an in-network dentist. A limited access area is a driving distance greater than 15 miles in urban areas, or greater than 35 miles in rural areas. You are responsible for any difference between the amount billed and our payment.

If you need assistance locating an in-network dentist in your area, please call us at 1-855-504-BLUE (2583).

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 plan option are combined between in- and out-of-network services. The total Annual Benefit Maximum will never be greater than the in-network Annual Benefit Maximum.

Annual Benefit Maximum:

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 Benefit Maximum is applicable to orthodontia benefits only. There are no other Lifetime Benefit Maximums under this Plan.

Lifetime Benefit 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 plan allowance for covered services. Before each appointment, verify the dentist is in-network at the service location.

Only dentists listed with their corresponding locations are in network. Not all dentists at a location may be in network and the same dentist at a different location may not be in network. It is your responsibility to ensure that the listed dentist 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. We pay for services rendered by an out-of-network dentist based on an out-of-network plan allowance. You will be responsible for your co-insurance percentage plus the billed amount over plan allowance.

Plan Allowance

Our plan allowance is the amount we use to determine our payment and your coinsurance for covered services. We determine our allowance as follows:

- For in-network dentists, based on our contracted dental rates. The member is not responsible for billed amounts that are more than the plan allowance.
- For out-of-network dentists, based on the out-of-network plan allowance. FAIR Health (a non-profit, non-insurance operation) data is utilized to determine the out-of-network plan allowance. The member is responsible for any amounts billed by out-of-network dentists that are above the plan allowance, plus their coinsurance amount.

Calendar Year

The calendar year refers to the plan year, which is defined as January 1, 2025 to December 31, 2025.

Emergency Services

Emergency or accident related services are covered the same as any other benefit.

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 2025 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 2025 plan year, such as crowns and implants.

Section 5 Dental Services and Supplies

Class A Basic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when determined to be necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet broadly accepted national standards of practice.
- The calendar year deductible is $0 if you use an in-network dentist. If you elect to use an out-of-network dentist, 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.
- The frequencies between your FEHB/PSHB and BCBS FEP Dental policy are combined, not separate. (ex. If 2 oral evaluations are covered under your FEHB/PSHB policy, and 2 oral evaluations are covered under BCBS FEP Dental a total of 2 oral evaluations will be covered and coverage will coordinate between policies)
- The following is an all-inclusive list of covered services.

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 Services

D0120 Periodic oral evaluation - established patient - *Limit 2 per calendar year - see additional benefit limitations at the end of this section*

D0140 Limited oral evaluation - problem focused - *Limit 1 per calendar year - see additional limitations at the end of this section*

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver - *Limit 2 per calendar year – see additional benefit limitations at the end of this section*

D0150 Comprehensive oral evaluation - new or established patient - *Limit 1 per calendar year - see additional benefit limitations at the end of this section*

D0160 Detailed and extensive oral evaluation - problem focused, by report - *Limit 1 per calendar year - see additional limitations at the end of this section*

D0180 Comprehensive periodontal evaluation - new or established patient - *Limit 1 per calendar year - see additional benefit limitations at the end of this section. Will alternate to a D0120 Periodic oral evaluation - established patient if billed with D4910 Periodontal maintenance.*

Diagnostic Services - continued on next page

Diagnostic Services (cont.)
D0210 Intraoral – comprehensive series of radiographic images - *Limit 1 every 60 months for any combination of comprehensive series of radiographic images*
D0220 Intraoral - periapical first radiographic image
D0230 Intraoral - periapical each additional radiographic image
D0240 Intraoral - occlusal radiographic image
D0250 Extra-oral – 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 of bitewings 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 Vertical bitewings - 7 to 8 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 for any combination of comprehensive series of radiographic images*
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

Class A Basic Diagnostic Services Notes and Limitations:

Non-problem focused evaluations – Limit 2 per calendar year

- D0120 Periodic oral evaluation - established patient, D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver, D0150 Comprehensive oral evaluation - new or established patient, and D0180 Comprehensive periodontal evaluation - new or established patient are combined and limited to a total of 2 per year.
  - D0150 Comprehensive oral evaluation - new or established patient and D0180 Comprehensive periodontal evaluation - new or established patient are combined and limited to 1 per calendar year.
  - Comprehensive oral evaluations in excess of the 1 per calendar year limit will be processed as a periodic evaluation.

Problem-focused evaluations – Limit 1 per calendar year

- D0140 Limited oral evaluation - problem focused and D0160 Detailed and extensive oral evaluation - problem focused, by report are combined and limited to 1 per calendar year.

Diagnostic Imaging

- 14 or more radiographic images on the same date of service will be processed as D0210 Intraoral – comprehensive series of radiographic images.
- Bitewing radiographic images with the same date of service as a panoramic radiographic image will be processed as D0210 Intraoral – comprehensive series of radiographic images.

Preventive Services

D1110 Prophylaxis - adult - *Limit 3 during the calendar year. Age 13 and under will be processed as D1120 Prophylaxis - child - Additional information on the following page.*

D1120 Prophylaxis - child - *Limit 3 during the calendar year. Age 14 and over will be processed as D1110 Prophylaxis - adult - 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 Topical application of fluoride – excluding varnish*

D1208 Topical application of fluoride – excluding varnish - *Limit 2 during the calendar year for patients up to age 22 in combination with D1206 Topical application of fluoride varnish*

D1351 Sealant - per tooth - *Unrestored 1st and 2nd 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 – permanent tooth - *Unrestored 1st and 2nd 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 tooth - *Unrestored 1st and 2nd 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 - *Limited to molars and premolars*

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*

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*

Class A Basic Preventive Services Notes:

- Prophylaxis and scaling in presence of generalized moderate or severe gingival inflammation: Limit 3 per calendar year for any combination of D1110 Prophylaxis - adult, D1120 Prophylaxis - child, and D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation. Age 13 and under will be processed as D1120 Prophylaxis - child, and age 14 and over will be processed as D1110 Prophylaxis - adult.
- Treatments such as fluorides are combined under one limitation by the plan. For example, D1206 Topical application of fluoride varnish and D1208 Topical application of fluoride – excluding varnish are combined and limited to 2 per calendar year for 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

Services Not Covered

Refer to Section 7 for a list of general exclusions

Class B Intermediate

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet broadly accepted national standards of practice.
- The calendar year deductible is $0 if you use an in-network dentist.
- If you elect to use an out-of-network dentist, 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. 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.
- For inlay services, if you decide to have the alternate benefit of a filling done, the time limitation would be 1 every 24 months.
- In-progress treatment for dependents of retiring TDP enrollees will be covered for the 2025 plan year. This is regardless of any current plan exclusions for care initiated prior to the enrollee's effective date.
- The following is an all-inclusive list of covered services.

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 tooth*
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 (anterior) - *Limit 1 every 24 months per surface per tooth*
D2390 Resin-based composite 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*
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 or more surfaces - *Limit 1 per tooth every 60 months* - ***An alternate benefit will be provided***
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***
D2650 Inlay - resin-based composite - one surface - *Limit 1 every 60 months* - ***An alternate benefit will be provided***
D2651 Inlay - resin-based composite - two surfaces - *Limit 1 every 60 months* - ***An alternate benefit will be provided***
D2652 Inlay - resin-based composite - 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 Reattachment of tooth fragment, incisal edge or cusp - *Limit to 1 every 24 months per surface per tooth, 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*
D2931 Prefabricated stainless steel crown – permanent tooth – *Limit 1 per tooth every 60 months for patients up to age 15*
D2940 Placement of interim direct restoration
D2951 Pin retention – per tooth, in addition to restoration
D2989 Excavation of a tooth resulting in the determination of non-restorability - *Limit 1 per tooth per lifetime*
D7288 Brush biopsy - transepithelial sample collection - *Limit 1 every 12 months*
Class B Intermediate Minor Restorative Services Notes: • Restorations are covered benefits only when necessary to replace tooth structure due to fracture or decay

Endodontic Services

D3110 Pulp cap - direct (excluding final restoration)

D3120 Pulp cap - indirect (excluding final restoration)

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament - *Primary teeth only, 1 per lifetime*

D3221 Pulpal debridement, primary and permanent teeth

D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development - *Limited to 1 per lifetime*

D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) - *Limited to 1 per lifetime*

D3240 Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) - *Limited to 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, 2 quadrants per date of service*

D4342 Periodontal scaling and root planing - one to three teeth per quadrant - *Limit 1 every 24 months, 2 quadrants per date of service*

D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation - *Limit 3 in combination with D1110 Prophylaxis - adult and/or D1120 Prophylaxis - child during calendar year*

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - *Service is covered for residual periodontal disease with inflammation and when necessary to treat specific sites that are unresponsive to prior active periodontal treatment*

D4910 Periodontal maintenance - *Limit 4 during the calendar year combined with adult prophylaxis, and scaling in presence of generalized moderate or severe gingival inflammation, after the completion of active periodontal therapy*

Class B Periodontal Services Notes:

Supporting documentation and criteria:

- 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 American Academy of Periodontology (AAP) labeled and dated (within 12 months of submitted procedure).
- Teeth to be treated must demonstrate at least 4 millimeter (mm) 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 1.5 mm apical to the cementoenamel junction (CEJ).

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.

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 – per tooth - *Limit 1 per year beginning 6 months after the initial installation*

D5611 Repair resin partial denture base, mandibular - *Limit 1 per year beginning 6 months after the initial installation*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D5612 Repair resin partial denture base, maxillary - *Limit 1 per year beginning 6 months after the initial installation*
D5621 Repair cast partial 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 missing or broken teeth – partial denture – per tooth - *Limit 1 per year beginning 6 months after the initial installation*
D5650 Add tooth to existing partial denture – per tooth - *Limit 1 per year beginning 6 months after the initial installation*
D5660 Add clasp to existing partial denture - per tooth - *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*
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 - *Disallowed if performed within 180 days of delivery of prosthesis*
D5851 Tissue conditioning, mandibular - *Disallowed if performed within 180 days of delivery of prosthesis*
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 necessitated by restorative material failure
D9120 Fixed partial denture sectioning - *Limited to 1 per 60 months*

Class B Intermediate Prosthodontic Services Notes:

- 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 dentist who fabricated the denture may be reimbursed for the service after insertion by another dentist (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.

Oral Surgery

D7111 Extraction, coronal remnants – primary tooth

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated

D7220 Removal of impacted tooth – soft tissue

D7230 Removal of impacted tooth – partially bony

D7240 Removal of impacted tooth – completely bony

D7241 Removal of impacted tooth - completely bony, with unusual surgical complications

D7250 Removal of residual tooth roots (cutting procedure)

D7251 Coronectomy - intentional partial tooth removal, impacted teeth only

D7270 Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth

D7272 Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)

D7280 Exposure of an unerupted tooth

D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant

D7311 Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant

D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant

D7321 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant

D7471 Removal of lateral exostosis (maxilla or mandible)

D7485 Reduction of osseous tuberosity

D7510 Incision and drainage of abscess – intraoral soft tissue

D7910 Suture of recent small wounds up to 5 cm

D7921 Collection and application of autologous blood concentrate product - *Limit 1 in 36 months*

D7953 Bone replacement graft for ridge preservation - per site - *Limit 1 every 60 months*

D7971 Excision of pericoronal gingiva

D7972 Surgical reduction of fibrous tuberosity – *Limit 1 every 6 months*

D7999 Unspecified oral surgery procedure, by report

Class B Intermediate Oral Surgery Notes:

- Bone replacement grafts for ridge preservation are excluded when done in connection with a tooth extraction or implant removal site when a planned implant is non-covered/non-eligible.

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 broadly accepted national standards of practice.
- The calendar year deductible is $0 if you use an in-network dentist.
- If you elect to use an out-of-network dentist, 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.
- If more than one service or procedure can be used to treat the dental condition, we reserve the right authorize an alternate, less costly covered service as deemed by a dental professional to be appropriate and to meet broadly accepted national standards of dental practice. If you and your dentist choose the more expensive treatment instead of the alternate benefit, you are responsible for the additional charges beyond the plan allowance for the alternate service.
- Pre-treatment estimates are not mandatory. However, we do recommend that your dentist submits a pre-treatment estimate if you are considering major or extensive dental care. Pre-treatment estimates should include a comprehensive treatment plan and necessary supporting documentation such as, chart notes, radiographic images, and photos. Benefits may be alternated to a less costly procedure that meets broadly accepted national standards of dental practice. 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 plan allowance is based on your current eligibility and benefits in effect at the time of the pre-treatment estimate. Submission of other claims or changes in eligibility or benefit may alter final payment. A pretreatment estimate is not a guarantee of benefits.
- All services requiring more than one visit are payable once all visits are completed.
- In-progress treatment for dependents of retiring TDP enrollees will be covered for the 2025 plan year. This is regardless of any current plan exclusions for care initiated prior to the enrollee's effective date.
- The following is an all-inclusive list of covered services.

You Pay:

High Option

- **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
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*
D2662 Onlay - resin-based composite - two surfaces - *Limit 1 every 60 months*
D2663 Onlay - resin-based composite - three surfaces - *Limit 1 per tooth every 60 months*
D2664 Onlay - resin-based composite - four or more surfaces - *Limit 1 per tooth every 60 months*
D2710 Crown - resin-based composite (indirect) - *Limit 1 every 60 months*
D2712 Crown - ¾ resin-based composite (indirect) - *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 predominantly 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 predominantly 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 predominantly 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*
D2794 Crown - titanium and titanium alloys - *Limit 1 per tooth every 60 months, including crowns, bridges, prosthetics*
D2932 Prefabricated resin crown – *Limit 1 per tooth every 60 months for patients up to age 15*
D2933 Prefabricated stainless steel crown with 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 up to age 15*
D2950 Core buildup, including any pins when required - *Limit 1 buildup procedure, per tooth every 60 months*
D2952 Post and core in addition to crown, indirectly fabricated - *Limit 1 buildup procedure, per tooth, every 60 months*
D2954 Prefabricated post and core in addition to crown - *Limit 1 buildup procedure, per tooth every 60 months*
D2955 Post removal
D2971 Additional procedures to customize a crown to fit under an existing partial denture framework - *Limit 1 every 60 months*
D2980 Crown repair necessitated by restorative material failure – *Limit 1 every 12 months*
D2981 Inlay repair necessitated by restorative material failure - *Limit 1 every 12 months*
D2982 Onlay repair necessitated by restorative material failure – *Limit 1 every 12 months*
D2983 Veneer repair necessitated by restorative material failure – *Limit 1 every 12 months*
D2990 Resin infiltration of incipient smooth surface lesions

Major Restorative Services - continued on next page

Major Restorative Services (cont.)

Class C Major Restorative Services Notes:

- For reporting and benefit purposes, the completion date for crowns is the cementation date.
- 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.)

Endodontic Services

D3310 Endodontic therapy, anterior tooth (excluding final restoration)

D3320 Endodontic therapy, premolar tooth (excluding final restoration)

D3330 Endodontic therapy, molar tooth (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

D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)

D3410 Apicoectomy - anterior

D3421 Apicoectomy - premolar (first root)

D3425 Apicoectomy - molar (first root)

D3426 Apicoectomy (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, 2 quadrants per date of service*

D4211 Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant – *Limit 1 every 36 months, 2 quadrants per date of service*

D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, 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, 2 quadrants per date of service*

D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant – *Limit 1 every 36 months, 2 quadrants per date of service*

Periodontal Services - continued on next page

Periodontal Services (cont.)
D4245 Apically positioned flap – *Limit 1 every 36 months, permanent teeth only*
D4249 Clinical crown lengthening – hard tissue
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant – *Limit 1 every 36 months, 2 quadrants per date of service*
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant – *Limit 1 every 36 months, 2 quadrants per date of service*
D4263 Bone replacement graft – retained natural tooth - first site in quadrant - *Limit 1 every 36 months, permanent teeth only*
D4264 Bone replacement graft – retained natural tooth - each additional site in quadrant - *Limit 1 every 36 months, permanent teeth only*
D4268 Surgical revision procedure, per tooth
D4270 Pedicle soft tissue graft procedure – *Limit 1 every 36 months*
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft – *Limit 1 every 36 months*
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area) – *Limit 1 every 36 months, permanent teeth only*
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 (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft – *Limit 1 every 36 months*
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site – *Limit 1 every 36 months*
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site – *Limit 1 every 36 months*
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site – *Limit 1 every 36 months*
D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - *Limit 1 per lifetime*
D4999 Unspecified periodontal procedure, by report

Class C Major Periodontal Services Notes:

Supporting documentation and criteria:

- 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 mm pocket depths
- Gingival flap procedure must be a surface adjacent to an edentulous/terminal tooth area

Gingivectomy or gingivoplasty performed in conjunction with restorative services are considered to be inclusive of the restoration and will not be reimbursed.

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.

Prosthodontic Services
D5110 Complete denture – maxillary – *Limit 1 every 60 months – Denied if using as an interim denture*
D5120 Complete denture - mandibular – *Limit 1 every 60 months – Denied if using as an Interim denture*
D5130 Immediate denture – maxillary – *Limit 1 every 60 months – Denied if using as an interim denture*
D5140 Immediate denture - mandibular – *Limit 1 every 60 months – Denied if using as an interim denture*
D5211 Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth) – *Limit 1 every 60 months - Denied if using as an interim denture*
D5212 Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth) – *Limit 1 every 60 months - Denied if using as an interim 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*
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) - *Limit 1 every 60 months – Denied if using as an interim denture*
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) - *Limit 1 every 60 months – Denied if using as an interim 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 an interim denture*
D5226 Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) – *Limit 1 every 60 months - Denied if using as an interim denture*
D5227 Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth) – *Limit 1 every 60 months – Denied if using as an interim denture*
D5228 Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth) – *Limit 1 every 60 months – Denied if using as an interim 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*
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 predominantly 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 predominantly 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*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
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 Retainer – resin bonded fixed prosthesis - *Limit 1 every 60 months*
D6600 Retainer inlay - porcelain/ceramic, two 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, two surfaces – *Limit 1 every 60 months*
D6603 Retainer inlay - cast high noble metal, three or more 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, two surfaces – *Limit 1 every 60 months*
D6607 Retainer inlay - cast noble metal, three or more surfaces – *Limit 1 every 60 months*
D6608 Retainer onlay - porcelain/ceramic, two surfaces - *Limit 1 every 60 months* - ***An alternate benefit will be provided***
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces - *Limit 1 every 60 months* - ***An alternate benefit will be provided***
D6610 Retainer onlay - cast high noble metal, two surfaces – *Limit 1 every 60 months*
D6611 Retainer onlay - cast high noble metal, three or more surfaces – *Limit 1 every 60 months*
D6612 Retainer onlay - cast predominantly base metal, two surfaces –*Limit 1 every 60 months*
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces – *Limit 1 every 60 months*
D6614 Retainer onlay - cast noble metal, two surfaces – *Limit 1 every 60 months*
D6615 Retainer onlay - cast noble metal, three or more surfaces – *Limit 1 every 60 months*
D6624 Retainer inlay – titanium – *Limit 1 every 60 months*
D6634 Retainer onlay - titanium – *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*
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 predominantly 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 predominantly 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 predominantly 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*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)

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 Prosthodontic Services Notes:

- For reporting and benefit purposes, the completion date for fixed partial dentures is the cementation date. The completion date is the insertion date for removable prosthodontic appliances. For immediate dentures, the dentist who fabricated the denture may be reimbursed for the service after insertion by another dentist (e.g., oral surgeon).
- 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.)

Implant Services

*D6010 Surgical placement of implant body: endosteal implant – *Limit 1 per site 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 supported 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 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 (predominantly 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 (predominantly base metal) – *Limit 1 every 60 months*

*D6064 Abutment supported cast 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 (predominantly base metal) – *Limit 1 every 60 months*

*D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal) – *Limit 1 every 60 months*

*D6072 Abutment supported retainer for cast metal FPD (high noble metal) – *Limit 1 every 60 months*

*D6073 Abutment supported retainer for cast metal FPD (predominantly 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*

Implant Services - continued on next page

Implant Services (cont.)
*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 when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments – *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*
*D6089 Accessing and retorquing loose implant screw - per screw - *Limit 1 per 12 months*
*D6090 Repair of implant/abutment supported 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 Re-cement or re-bond implant/abutment supported crown - *Limit 1 every 60 months*
*D6093 Re-cement 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*
*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 or defects surrounding a single implant, and surface cleaning of the 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 or 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*
*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*

Implant Services - continued on next page

Implant Services (cont.)

*D6195 Abutment supported retainer – porcelain fused to titanium and titanium alloys - *Limit 1 every 60 months*

*D7994 Surgical placement: zygomatic implant – *Limit 1 per tooth every 60 months*

Class C Major Implant Services Notes:

- Implant services listed with an asterisk **(*)** often have the choice of a lower cost treatment. If you or your provider should choose the more costly treatment or service, the lower cost alternate benefit will be allowed.
- 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.)

Oral Surgery

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)

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 broadly accepted national standards of practice.
- There is no calendar year deductible.
- We pay 50% of the plan allowance up to the lifetime maximum. The lifetime maximum for orthodontic services (clear aligners or traditional braces) depends on the option in which you enroll and if you choose to receive services from a network dentist. If you are covered by High Option, the lifetime maximum is up to $3,500. However, the plan allowance (see page 16) depends on the participation status of the dentist. If you are enrolled in Standard Option, the lifetime maximum for services rendered by an in-network dentist is up to $2,500 and for services rendered by an out-of-network dentist the lifetime maximum is up to $1,250. Your out-of-pocket expenses will be higher when using an out-of-network dentist.
- In no instance will BCBS FEP Dental allow more than $2,500 in orthodontic benefits 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 the plan and are subject to alternate benefit, coinsurance, maximum benefit limits, and the other limitations described in this plan document.
- We cover traditional orthodontic treatment (braces) as well as clear aligners. 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 orthodontic 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 radiographic images 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.
- The following is an all-inclusive list of covered services.

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 intraoral 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 – *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, restoration for misalignment of teeth, or restoring tooth structure from attrition, erosion or abrasion.
- Over-the-counter or mail order orthodontic treatments

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 broadly accepted national standards of practice.
- The calendar year deductible is $0, if you use an in-network dentist.
- If you elect to use an out-of-network dentist, 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 is an all-inclusive list of covered services.

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 total units of anesthesia (combined with D9223 Deep sedation/general anesthesia – each subsequent 15 minute increment)*

D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment - *Up to 8 total units of anesthesia (combined with D9222 Deep sedation/general anesthesia – first 15 minutes)*

D9230 Inhalation of nitrous oxide/analgesia, anxiolysis - *For children 5 and under and other individuals with a medical condition that may require it*

D9239 Intravenous moderate (conscious) sedation/analgesia – first 15 minutes - *Up to 8 total units of anesthesia (combined with D9243 Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment)*

D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment - *Up to 8 total units of anesthesia (combined with D9239 Intravenous moderate (conscious) sedation/analgesia- first 15 minutes)*

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 Dentist

You may visit any dentist and you will receive in-network benefits for any covered benefits received internationally. 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 locating an English-speaking dentist, 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-BLUE (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. The claim form can be accessed online at www.bcbsfepdental.com/claimform. 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 rating area for all international locations. Use rating area 1 in the rate table to find international premium amounts.

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 services and treatment unless we determine it is necessary for the prevention, diagnosis, care, or treatment of a covered condition.**

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 broadly accepted national standards of practice.

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 that are experimental or investigational;
- Services and treatment that are for any illness or bodily injury that 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 that are not dentally necessary or do not meet broadly 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 radiographic images, or any costs associated with forwarding/mailing copies of your records, charts or radiographic images;
- 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 that 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, restoration for misalignment of teeth, or restoring tooth structure from attrition, erosion or abrasion;
- 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 dentist for completing dental forms;
- Adjustment of a denture or bridgework that 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 1st and 2nd permanent molars;
- 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 is excluded for individuals over 5 years of age in the absence of a medical condition that may require it;
- Oral sedation;
- Periodontal medicament carrier;
- Bone grafts when done in connection with apicoectomies, non-covered/non-eligible implants, or a tooth extraction or implant removal site when a planned implant is non-covered/non-eligible;
- Veneers;
- Blood glucose level test - in-office using a glucose meter;
- Duplicate/copy patient's records;
- When two or more services are submitted and the services are considered part of the same service, we 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), we 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 dentist submit your claims directly to your FEHB/PSHB 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/PSHB plan).

If you need to send in a 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 and any requested documentation within 24 months from the date the 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 our determination. Non-covered services do not qualify for the disputed claims process.

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/contactus.

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 within 60 days from the date of our determination. 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. You must file the appeal in writing to BCBS FEP Dental within 60 days from the date of our determination.

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

Alternate 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 Obtain Care.
Annual Benefit Maximum	The maximum annual benefit that a member can receive.
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, 2025 through December 31, 2025. Also referred to as the plan year.
Class A Services	Basic services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and radiographic images.
Class B Services	Intermediate services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling and root planing, 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 dentist 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 must meet broadly accepted national standards of practice.
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	Generally accepted dental protocol means that a dental service or treatment is performed in accordance with broadly accepted national standards of practice, 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 initiated in 2024 that will be completed in 2025.
Incur/Incurred	A covered service is deemed incurred on the date care, treatment or service is received.

Plan Allowance	The amount we use to determine our payment for services. If services are provided by an in-network dentist, the allowance is based on the negotiated fee they accept as payment in full. If services are provided by an out-of-network dentist, the plan allowance is based on the out-of-network plan allowance.
Network Allowance	Network allowance means the allowance per procedure that BCBS FEP Dental has negotiated with the dentist, and they have agreed to accept as payment in full.
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).
TRICARE-eligible individual (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 services. Note: There are no waiting periods for BCBS FEP Dental.
We/Us	BCBS FEP Dental
You	Enrollee or eligible family member.

Discounts

Save with Blue365® Discounts

BCBS FEP Dental presents Blue365, a program that provides easy access to premier health and wellness products and services to help members build a path to live a healthy life. With Blue365, members get access to over 100 handpicked discounts from leading brands and there is no limit to how many deals a member can redeem. Many deals are available and new ones are constantly being added, including:

- **Fitness** – Get the support you need to achieve your fitness goals with deals on wearable devices, apparel, home gym equipment, virtual workout classes and in-person gym access.
- **Healthy Eyes and Ears** – Between replacing hearing aids and correcting your vision, caring for your eyes and ears can get expensive quickly. Blue365 provides up to 60% off hearing aids, discounts on LASIK surgery and more.
- **Home and Family** – Your home and family can influence your mental, physical, emotional, and financial well-being. Blue365 offers discounts on premium vitamins and supplements, pet insurance, fertility services, products for new parents, financial offers, family health and more.
- **Nutrition** – Blue365 offers a variety of deals that help you eat right. Choose from meal kit subscriptions, chef-prepared entrees, weight management plans and more.
- **Personal Care** – A little self-care can go a long way toward improving your mental health. Blue365 offers exclusive discounts on skin care products, oral care products, tooth-whitening kits, mindfulness subscriptions and much more.
- **Travel** – Sometimes a vacation is all you need to escape stress and reset. Blue365 makes family getaways more affordable with discounted access to lodging, car rentals and vacation packages.

Each week, Blue365 members can receive great health and wellness deals via email. With Blue365, there is no paperwork to fill out. Just visit http://www.bcbsfepdental.com/additional-discounts and select Visit Blue365 deals to learn more about the various Blue365 vendors and discounts.

BCBS FEP Dental does not recommend, endorse, warrant, or guarantee any specific Blue365 vendor or item. Vendors and the program are subject to change at any time.

Tools and Resources

AskBlue BCBS FEP Dental Plan Finder
Description: 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 www.askblue.bcbsfepdental.com.

Website
Description: On our website, bcbsfepdental.com, you can access tools and resources that help you get the most out of your coverage, including:

- Compare benefit plans
- Read oral health and wellness articles
- Learn how to enroll
- Opt-in for email communication
- Find a dentist
- Dental Pricing Tool
- Glossary of dental terms
- Dental anatomy
- And much more

Member Portal
Description: 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:

- Opt-in for email communication
- Opt-in for paperless Explanation of Benefits (EOBs)
- View/share EOBs
- View/share/download ID cards
- Submit online claims
- Live chat with customer service
- And much more

BCBS FEP Dental Mobile Application
Description: BCBS 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 BCBS 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 EOB, view/share member ID cards, and locate in-network dentists. Additional features include:

- Submit online claims
- Dental Pricing Tool
- Brush & floss timer
- Torp's Interactive timer for children
- Opt-in for email communication

Social Media
Description: Follow us @fepblue on Facebook, Instagram, YouTube and LinkedIn 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.gov or call 1-877-888-FEDS (3337), TTY number 1-877-889-5680.
- Out-of-network services under Class 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 (Orthodontic) Services Class D Orthodontic Services are subject to a Lifetime Maximum Benefit 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	65%	80%

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Standard Option Benefits (cont.)	You Pay	
	In-Network	Out-of-Network
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%
Class D (Orthodontic) Services Class D Orthodontic Services are subject to a Lifetime Maximum Benefit up to $2,500 for In-network per treatment or $1,250 for Out-of-network per treatment	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 dentists, BCBS FEP Dental, BENEFEDS, or OPM.
- Let only the appropriate dentists review your clinical record or recommend services.
- Avoid using dentists 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 dentist 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 dentist 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 dentist and ask for an explanation. There may be an error.
  - If the dentist does not resolve the matter, call us at 1-855-504-BLUE (2583) and explain the situation, you will be required to state your complaint in writing to us.
- **Federal Civilians** - 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
  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 or incapable of self-support)
  Your child over age 23 if they are enrolled in school (unless they are disabled or 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

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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, 563	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	$18.95	$37.90	$56.84	$41.06	$82.12	$123.15
2	$21.23	$42.46	$63.69	$46.00	$92.00	$138.00
3	$23.10	$46.21	$69.31	$50.05	$100.12	$150.17
4	$25.03	$50.05	$75.08	$54.23	$108.44	$162.67
5	$28.01	$56.02	$84.03	$60.69	$121.38	$182.07

Rating Area	Standard - Bi-Weekly			Standard - Monthly		
	Self Only	Self Plus One	Self and Family	Self Only	Self Plus One	Self and Family
1	$10.19	$20.39	$30.58	$22.08	$44.18	$66.26
2	$11.17	$22.33	$33.50	$24.20	$48.38	$72.58
3	$12.69	$25.38	$38.07	$27.50	$54.99	$82.49
4	$13.70	$27.40	$41.10	$29.68	$59.37	$89.05
5	$15.12	$30.24	$45.37	$32.76	$65.52	$98.30

Blue Cross Blue Shield FEP Vision®

www.bcbsfepvision.com

1-888-550-BLUE (2583)

BlueCross BlueShield FEP Vision®

2025

A PPO Vision Plan, available nationwide and overseas

IMPORTANT
- Rates: Back Cover
- Changes for 2025: Page 5
- Summary of Benefits: Page 30

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

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 Blue Cross Blue Shield FEP Vision under the Blue Cross and Blue Shield Association's contract OPM02-FEDVIP-02AP-04 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

Blue Cross Blue Shield FEP Vision
PO Box 507
Troy, NY 12181

1-888-550-BLUE (2583)
TTY: 1-800-523-2847
www.bcbsfepvision.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. You, and your family members, do not have a right to benefits that were available before January 1, 2025 unless those benefits are also shown in this brochure.

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 eligible family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits.

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

BCBS FEP Vision is responsible for the selection of in-network providers in your area. Contact us at 1-888-550-BLUE (2583) or TTY: 1-800-523-2847 for the names of participating providers or to request a provider directory. You may also request or view the most current directory via our website at **www.bcbsfepvision.com**. 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-network. If your provider is not currently participating in the provider network, you can nominate them to join. Nomination forms are available on our website, or call us and we will take your nomination over the phone. 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. **Please be aware that the BCBS FEP Vision network is different from the network of your health plan.**

This BCBS FEP Vision plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program / Postal Service Health Benefits (PSHB) 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, www.bcbsfepvision.com and then click on the "Privacy, Legal, link 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 1-888-550-BLUE (2583) or TTY: 1-800-523-2847.

Discrimination is Against the Law

BCBS FEP Vision 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 Vision does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

Table of Contents

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.gov. 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; e.g., 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 2024 Open Season, your coverage will begin on January 1, 2025. Premium deductions will start with the first full pay period beginning on/after January 1, 2025. 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 11, 2024 through midnight Eastern time December 9, 2024. 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.

How We have Changed For 2025

New for 2025!

Changes to Standard Option Only:

- We added benefit coverage for contact lens evaluation, fitting and follow-up for non-specialty lenses with a 55 copay.

Changes to Both High Option and Standard Option:

- We reduced the copay for retinal imaging from $39 to $29.

Changes to our Network:

- We are expanding our online presence by adding Contacts Direct, https://www.contactsdirect.com/ to our network.

Changes to our Blue365® Program:

- We increased the discount vendors in our Blue365 Program. Now there are over 100 different discounts in categories such as, fitness, healthy eyes and ears, home and family, nutrition, personal care, and travel. (See page 22)

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), the Postal Service Health Benefits (PSHB) Program or the Health Insurance Marketplace (Exchange) and your position is not excluded by law or regulation. Enrollment in the FEHB/PSHB Program or the Health Insurance Marketplace (Exchange) is not required.

Temporary/Seasonal Employees

Certain temporary, intermittent, and seasonal Federal and U.S. Postal Service employees are now eligible to enroll in FEDVIP. To be eligible, these employees must be expected to work 130 hours per calendar month for at least 90 days. In addition, certain firefighters hired under a temporary appointment and intermittent emergency response personnel are eligible to enroll in FEDVIP. The employing agency must determine and notify these employees of their eligibility.

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/PSHB 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/PSHB 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. An unremarried former spouse who meets the U.S. Department of Defense's 20-20-20 and/or 20-20-15 benefit eligibility requirements may only enroll in a self-only FEDVIP vision plan. 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/PSHB 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 vision plan.
- FEHB/PSHB 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).
- Temporary/seasonal employees who do not meet the 130 hours per calendar month for 90 days.

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.gov) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (3337), TTY number 1-877-889-5680 to enroll or change your enrollment.

If you are currently enrolled in a FEDVIP vision plan and want to switch to BCBS FEP Vision, you must change enrollment through BENEFEDS. If you do not want to change plans or options, your enrollment will continue automatically. Please note: your plan's premiums may change for 2025.

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; e.g., 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 (TEI), you may enroll in a dental and/or vision plan during the November 11, 2024 through midnight Eastern time December 9, 2024, Open Season. Coverage is effective January 1, 2025.

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;
- an employee returning to service following a break in service of at least 31 days; or
- a TRICARE-eligible individual

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

Opportunities to Enroll or Change Enrollment

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 (LWOP)
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.

Opportunities to Enroll or Change Enrollment

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.
- 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.

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 a dental or a vision 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.

VA Exception for Cancellation

Generally, you may cancel your enrollment only during the annual open season. However, if you are a FEDVIP enrollee paying premiums on a **post-tax basis**, and you, your family member, or TEI family member becomes eligible for VA dental or vision benefits, then you **may** change your enrollment type or cancel your enrollment within 60 days of receiving notification of VA dental or vision eligibility. This 60-day period may fall outside of open season. VA dental or vision eligibility documentation must be submitted to OPM via the BENEFEDS mailbox (benefedsportal@opm.gov) within 60 days of notification to support the FEDVIP enrollment change or cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the open season effective date. An eligible family member's coverage also ends upon the effective date of the cancellation.

If you are a FEDVIP enrollee paying premiums on a **pre-tax basis,** and you, your family member, or TEI family member becomes eligible for VA dental or vision benefits, then you **may not** change or cancel your FEDVIP enrollment until the next open season.

FEDVIP enrollees can verify if they are paying their premiums on a pre- or post-tax basis by contacting BENEFEDS at 1-877-888-FEDS (3337), TTY number 1-877-889-5680.

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;
- a sponsor or primary enrollee leaves active duty;
- you 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;
- you are making direct premium payments to BENEFEDS and you stop making the payments;
- it is the last day of the pay period for which BENEFEDS received premium following the loss of eligibility;
- you cancel the enrollment during open season.

Coverage for a family member ends when:

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

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

Please review IRS - Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans (www.irs.gov/forms-pubs/about-publication-969) for additional information about carryover and contribution amounts for the upcoming tax year. If you have an HCFSA or LEX HCFSA FSAFEDS account and you have not exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over a set maximum amount 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 31st. You must also actively re-enroll in a health care or limited expense account during the next open season to be carryover eligible. Your re-enrollment must meet the minimum contribution amount for the plan year. If you do not re-enroll, 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 permitted. This is known as the "Use-it-or-Lose-it" rule. Carefully consider the amount you will elect.

Current FSAFEDS participants must re-enroll to participate in the program next year.

See www.fsafeds.gov 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 may use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB/PSHB and/or FEDVIP plans.

Section 3 How You Obtain Care

Identification Cards/Enrollment Confirmation

Two ID cards are issued for each member, regardless of coverage option. Existing members' ID cards are still valid. If additional cards are needed, you may request them through our website, www.bcbsfepvision.com, or call us at 1-888-550-BLUE (2583) or TTY: 1-800-523-2847. All eligible dependents listed on your enrollment share your identification number. You do not need an ID card for each member of your family. You can print a temporary ID card online in our member portal at www.bcbsfepvision.com/portal, view it in our mobile app or contact customer service to verify your eligibility in the plan.

Plan Providers

We list in-network plan providers in the provider directory, which is updated frequently. The most current list can be found on our website at www.bcbsfepvision.com. It is your responsibility to ensure that the provider chosen is an active participant in the program, at the time you receive services. **The BCBS FEP Vision network is specific to routine vision care and is different from the network for your medical plan**.

In some cases, due to local regulations or business practices, the doctor may be independent of the retail location. You should confirm that both the doctor and the retail location are participating prior to seeking services.

In-Network

We negotiate rates with vision care providers to help save you money. BCBS FEP Vision in-network providers are referred to as participating providers and are contracted through Davis Vision. When scheduling an appointment, you should identify yourself as a member of the FEDVIP BCBS FEP Vision plan. The provider is then responsible for verifying eligibility and submitting the claim by contacting BCBS FEP Vision either by telephone or via the web. If you use a participating provider to obtain covered care, benefits are paid at the in-network level. You are responsible for amounts over the plan allowance, lens copays, and optional lens and treatment copays.

BCBS FEP Vision also offers several in-network online options such as: contactsdirect.com, 1800contacts.com, befitting.com, glasses.com, lenscrafters.com, targetoptical.com, visionworks.com and warbyparker.com. Check our website at www.bcbsfepvision.com for additional options.

Under Standard Option, you must stay in-network for covered services. If you receive care from a non-participating provider, we will not pay for any services unless you reside in a limited access area. Please see Section 4, Your Cost For Covered Services.

Out-of-Network

Under High Option, you may obtain care from any licensed eye care provider. If the provider you use is not part of our network, benefits will be considered out-of-network. Because these providers are out of the BCBS FEP Vision network, we will reimburse you up to the maximum reimbursement amount allowed by the plan (see fee schedule allowances as described in Section 4, Your Cost For Covered Services). You are responsible to pay the out-of-network provider and then submit a claim along with an itemized receipt to receive your reimbursement (see Section 8, Claims Filing and Disputed Claims Processes, for information).

Under Standard Option, you must stay in-network for covered services. If you receive care from a non-participating provider, we will not pay for any services unless you reside in a limited access area. Please see Section 4, Your Cost For Covered Services.

Pre-Authorization

Pre-authorization is only required for:

- Medically necessary contact lenses in the treatment of certain eye health conditions and is obtained by the participating provider.
- The treatment of low vision and is obtained by the participating provider.
- The child benefit for children 13 and under if their prescription changes.

- The condition benefit for members with certain conditions (diabetes, hypertension, kidney disease, dementia, pregnancy, HNCRT (Head and Neck Cancer Patients with Radiation Therapy) if their prescription changes.

FEHB/PSHB First Payor

When you visit a provider who participates with both your FEHB/PSHB plan and your FEDVIP plan, and the FEHB/PSHB plan provides routine vision care and services, the FEHB/PSHB plan will pay benefits first. The FEDVIP plan allowance will be the prevailing charge in these cases. You are responsible for the difference between the FEHB/PHSB and FEDVIP benefit payments and the FEDVIP plan allowance. We are responsible for facilitating the process with the primary FEHB/PSHB payor.

Coordination of Benefits

We do not coordinate benefits with non-FEHB/non-PSHB health plans.

Limited Access Areas

If you live in an area that does not have adequate access to an BCBS FEP Vision network provider and you receive covered services from an out-of-network provider, we will pay up to 100% of our plan allowance listed below. You are responsible for any difference between the amount billed and our payment. To determine if you are in a limited access area call us at 1-888-550-BLUE (2583) or TTY: 1-800-523-2847.

Members who reside in areas not meeting access standards* can visit an out-of-network provider, pay billed charges and then be reimbursed based on the plan allowance.

***NOTE: Access Standards**
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 vision 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 vision care preferred provider.

Plan Allowance: The maximum benefit payment for services provided in areas not meeting the access standards are shown in the chart below. You are responsible for charges billed over the amounts shown.

Services/Material: Vision Care Exam
High Option: We pay up to $50
Standard Option: We pay up to $50

Services/Material: Single Vision Lenses
High Option: We pay up to $72
Standard Option: We pay up to $72

Services/Material: Bifocal Lenses
High Option: We pay up to $109
Standard Option: We pay up to $109

Services/Material: Trifocal Lenses
High Option: We pay up to $136
Standard Option: We pay up to $136

Services/Material: Lenticular Lenses
High Option: We pay up to $136
Standard Option: We pay up to $136

Services/Material: Contact Lenses
High Option: We pay up to $150
Standard Option: We pay up to $140

Services/Material: Medically Necessary Contact Lenses
High Option: We pay up to $600
Standard Option: We pay up to $600

Services/Material: Frames
High Option: We pay up to $200
Standard Option: We pay up to $140

Section 4 Your Cost for Covered Services

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

Copayment

A co-payment is a fixed amount of money you pay to the provider when you receive services.

Example: The BCBS FEP Vision High Option and Standard Option plans have a $0 copay for a vision care exam. However, Standard Option has a $10 copay for lenses. This copay does not apply to High Option. Please refer to Section 5 for further details.

In-Network Services

When you visit a BCBS FEP Vision network doctor, your vision care exam is covered in full and prescription glasses or contacts are covered after any co-payments. If you visit an in-network independent provider, you will also receive 20% off any out-of-pocket costs over your frame allowance and a savings of 15% on any balance over your conventional contact allowance. To receive covered benefits, you must stay in-network if you are enrolled in Standard Option.

Out-of-Network Services

If you are enrolled in Standard Option, you must stay in-network for covered services. If you receive care from a non-participating provider, we will not pay for any services unless you reside in a limited access area. Please see details described in (Section 3, How to Obtain Care) for information on limited access areas.

If you are enrolled in High Option, you'll get more out of your coverage and pay lower out-of-pocket costs when you see a BCBS FEP Vision network provider. Plus, there are no claim forms to submit when you see an in-network provider. When you visit an out-of-network provider, you will be reimbursed according to the schedule shown in the chart below. Only items listed in the chart below are reimbursable. You will be responsible for charges billed over the amounts shown.

Services/Material: Vision Care Exam
We Pay: Up to $30
Services/Material: Single Vision Lenses
We Pay: Up to $25
Services/Material: Bifocal Lenses
We Pay: Up to $35
Services/Material: Trifocal Lenses
We Pay: Up to $45
Services/Material: Lenticular Lenses
We Pay: Up to $45
Services/Material: Elective Contact Lenses
We Pay: Up to $75
Services/Material: Medically Necessary Contact Lenses
We Pay: Up to $225
Services/Material: Frames
We Pay: Up to $30

Section 5 Vision Services and Supplies

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 protocols.

- All BCBS FEP Vision **independent providers** are required to extend a 20% discount to all members that purchase additional frames, and/or spectacle lenses and/or daily wear contact lenses, and a 10% discount when purchasing additional disposable contact lenses. This discount can either be in conjunction with their benefit (pair 2, 3, etc.) or at any other time. The materials portion of the member's benefit does not need to be exhausted first in order for the member to receive this discount.
- Participating providers may offer fashion brand frames, such as Gucci or Polo, for which regular benefits apply. Benefits do not apply at these fashion brand stores directly if they are not participating providers.
- We offer retinal imaging at a $29 copay for both High Option and Standard Option.
- We offer additional benefits for children age 13 and under. See full details below.
- We offer additional benefits for members with specific conditions (e.g., diabetes, hypertension) see full details below.
- We offer an additional $50 frame allowance at MyEyeDr. High Option members have a $250 allowance and Standard Option members have a $190 allowance at all MyEyeDr. locations.
- We added https://www.contactsdirect.com to our online network.

Benefit Description	You Pay	
Diagnostic	**High**	**Standard**
Vision Care Exam: covered in full once every calendar year. • Includes dilation, if professionally indicated • Includes refraction only if vision health exam is billed to medical; an EOB from medical insurance is required. BCBS FEP Vision doctors provide a comprehensive exam that focuses on your eye health and overall wellness	In-Network: Nothing Out-of-Network: Expenses in excess of the fee schedule allowance of $30	In-Network: Nothing Out-of-Network: All charges
Retinal Imaging	In-Network: $29 copay Out-of-Network: All charges	In-Network: $29 copay Out-of-Network: All charges
Eyewear	**High**	**Standard**
Lenses: one pair every calendar year. Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses. **Note:** All lenses include scratch-resistant coating with no additional copayment. There may be an additional charge at in-network national and online retailers. **Note: You may choose prescription glasses or contacts.**	In-Network: Nothing Out-of-Network: Expenses in excess of fee schedule allowance of: $25 single vision $35 bifocal $45 trifocal $45 lenticular	In-Network: $10 copay Out-of-Network: All charges

Eyewear - continued on next page

Benefit Description	You Pay	
Eyewear (cont.)	**High**	**Standard**
Optional Lenses and Treatments	In-Network Only	In-Network Only
Anti-Reflective (AR) Coatings - Standard/Premium/Ultra/Ultimate	$20/$33/$45/$70	$35/$48/$60/$85
Blended Segment Lenses	$20	$20
Blue Light Filtering Lenses	$15	$15
Digital single vision & computer lenses	$30	$30
Edge Polish	$22	$22
Hi-Index Lenses (1.67/1.74)	$55/$120	$55/$120
High Luster Edge Polish	$70	$70
Intermediate Vision Lenses	$30	$30
Mirror Coating	$86	$86
Photochromic Glass Lenses	$20	$20
Plastic Photosensitive Lenses (Transitions®)	No-Copay	$65
Polarized Lenses	$75	$75
Polycarbonate Lenses	No-Copay	No-Copay
Premium Scratch Resistant	$30	$30
Progressives Lenses - Standard/Premium/Ultra/Ultimate	$0/$40/$90/$125	$50/$90/$140/$175
Rimless Drill	$66	$66
Roll & Polish	$16	$16
Roll Edge	$24	$24
Scratch Protection Plan	$0	$0
Scratch Resistant Coating	$0	$0
Scratch Resistant Premium	$30	$30
Slab Off	$186	$186
Specialty Lens (myodisc/double sided grind) and Lenticular)	$206	$206
Tinted Lenses	No-Copay	No-Copay
Trivex Lenses	$50	$50
Ultraviolet Protective Coating	No-Copay	No-Copay
Frames: covered once every calendar year. Receive an additional $50 towards your frame allowance at all MyEyeDr. locations. ***Note:** Additional discounts are available from in-network independent providers. In-network national and online retailers do not offer the discount. **Note:** "Collection" frames, including newly introduced Green Eco sustainable Collection, with retail values up to $195 are available at no cost at most in-network independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	In-Network: Collection Frames: Nothing Nothing for frames up to $200 frame allowance. Additionally, a 20% discount applies to any amount over $200* $250 frame allowance at all MyEyeDr. locations. The additional 20% discount does not apply. Out-of-Network: Expenses in excess of fee schedule allowance of $30	In-Network: Collection Frames: Nothing Nothing for frames up to $140 frame allowance. Additionally, a 20% discount applies to any amount over $140* $190 frame allowance at all MyEyeDr. locations. Additional 20% discount does not apply. Out-of-Network: All charges

Benefit Description	You Pay	
Contact Lenses	**High**	**Standard**
Contact Lenses: covered once every calendar year – in lieu of eyeglasses. ***Note:** Additional discounts are available from in-network independent providers. In-network national and online retailers do not offer the discount. ****Note: Pre-authorization is required.**	In-Network: Expenses in excess of a $150 allowance. Additionally, a 15% discount applies to any amount over $150.* The evaluation, fitting and follow-up care is covered in full for Non-Specialty contact lenses. For Specialty lenses (including, but not limited to, toric, multifocal and gas permeable lenses), you receive $60 toward the contact lens evaluation and fitting, plus a 15% discount off the balance over $60*. Participating providers will bill you for anything over the $60 less the discount so you do not have to file a claim. Expenses in excess of $600 for medically necessary contact lenses.** Out-of-Network: Expenses in excess of fee schedule allowance of: $75 elective contact lenses $225 medically necessary contact lenses	In-Network: Expenses in excess of a $140 allowance. Additionally, a 15% discount applies to any amount over $140.* The evaluation, fitting and follow-up care is covered with a $55 copay for non-specialty contacts, plus a 15% discount off the balance Participating providers will bill you for anything over the $55, less the discount, so you do not have to file a claim. Expenses in excess of $600 for medically necessary contact lenses.** Out-of-Network: All charges

Warranty

BCBS FEP Vision "Collection" frames and all eyeglass lenses manufactured in BCBS FEP Vision laboratories are guaranteed for one year from the original date of dispensing. Warranty limitations may apply to provider or retailer supplied frames and/or eyeglass lenses. Please ask your provider for details of the warranty that is available to you.

Child Benefit

Benefit applies to children 13 years of age and under.

In-Network Only – High Option and Standard Option

One additional vision care exam is covered in full every calendar year.

If the child's prescription changes, one additional pair of lenses is covered in full for High Option members; there is a $10 copay for Standard Option members. Also, one additional pair of frames is covered if the child's prescription changes, with Collection frames covered in full and non-Collection frames subject to the allowance, plus a 20% discount on any amount over the allowance.

The prescription must have changed at least a 0.5 diopter or the seg height changed at least a 5.0 millimeter, or lens type changed, e.g. (from single vision to bifocal). **Pre-authorization is required.**

Medical Condition Benefit

This benefit provides additional coverage to members who have been diagnosed with the following conditions: diabetes, hypertension, kidney disease, dementia, pregnancy, HNCRT (Head and Neck Cancer Patients with Radiation Therapy).

In-Network Only - High Option and Standard Option

One additional vision care exam is covered in full every calendar year.

If the prescription changes, one additional pair of lenses is covered in full for High Option members; there is a $10 copay for Standard Option members.

The prescription must have changed at least 0.5 diopter or the seg height changed at least a 5.0 millimeter, or lens type changed, e.g. (from single vision to bifocal). **Pre-authorization is required.**

Low Vision

Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. After pre-authorization by BCBS FEP Vision, covered low vision services (both in- and out-of-network) will include one comprehensive low vision evaluation every five years, with a maximum charge of $300; maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period, with a maximum charge of $100 each visit. **Digital devices such as iPads, cell phones, etc. are not covered.** Participating providers will obtain the necessary **pre-authorization** for these services.

Medically Necessary Contact Lenses

Medically Necessary Contact Lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. Clinical documentation may be requested from your doctor to support the medically necessary contact lenses. Contact lenses may be determined to be medically necessary in the treatment of specific eye conditions such as:

Keratoconus

High Ametropia

Anisometropia

Aphakia

Aniridia

Moderate to Severe Dry Eye Disease

Irregular Astigmatism

Having the diagnosis of a particular eye condition does not guarantee that the contact lenses would be determined to be medically necessary per the criteria outlined in the clinical guidelines.

Discounts

Save with Blue365® Discounts

BCBS FEP Vision presents Blue365, a program that provides easy access to premier health and wellness products and services to help members build a path to live a healthy life. With Blue365, members get access to over 90 handpicked discounts from leading brands and there is no limit to how many deals a member can redeem. Many deals are available and new ones are constantly being added, including:

- **Fitness** – Get the support you need to achieve your fitness goals with deals on wearable devices, apparel, home gym equipment, virtual workout classes and in-person gym access.
- **Healthy Eyes and Ears** – Between replacing hearing aids and correcting your vision, caring for your eyes and ears can get expensive quickly. Blue365 provides up to 60% off hearing aids, discounts on LASIK surgery and more.
- **Home and Family** – Your home and family can influence your mental, physical, emotional, and financial well-being. Blue365 offers discounts on premium vitamins and supplements, pet insurance, fertility services, products for new parents, financial offers, family health and more.
- **Nutrition** – Blue365 offers a variety of deals that help you eat right. Choose from meal kit subscriptions, chef-prepared entrees, weight management plans and more.
- **Personal Care** – A little self-care can go a long way toward improving your mental health. Blue365 offers exclusive discounts on skin care products, oral care products, tooth-whitening kits, mindfulness subscriptions and much more.
- **Travel** – Sometimes a vacation is all you need to escape stress and reset. Blue365 makes family getaways more affordable with discounted access to lodging, car rentals and vacation packages.

Each week, Blue365 members can receive great health and wellness deals via email. With Blue365, there is no paperwork to fill out. Just visit http://www.bcbsfepvision.com/additional-discounts and select Visit Blue365 deals to learn more about the various Blue365 vendors and discounts. BCBS FEP Vision does not recommend, endorse, warrant, or guarantee any specific Blue365 vendor or item. Vendors and the program are subject to change at any time.

Laser Vision Correction: BCBS FEP Vision members can realize substantial discounts on laser correction procedures using the QualSight Network. For more details visit our website at https://bcbsfepvision.com/lasik/.

Your Hearing Network: BCBS FEP Vision members have access to a hearing health care program through Your Hearing Network (YHN). For more details visit our website at https://bcbsfepvision.com/additional-discounts/.

Tools and Resources

Vision Cost Estimator Tool
Description: The vision cost estimator tool is a web-based, educational know-before-you-go resource that enables users to estimate their approximate out-of-pocket costs when visiting an in-network eye care provider, reducing financial surprises and demonstrating in-network value. The tool also provides descriptions on topics such as retinal imaging, eyewear preferences, the benefits of various lenses and other add-ons, and much more. Try our cost estimator tool by visiting https://bcbsfepvision.com/costestimator.

Vision Simulator
Description: Experience vision issues with the Vision Simulator: See through the eyes of someone affected by glaucoma, cataract, diabetic retinopathy, presbyopia, glare, and macular degeneration, and experience the impact these common conditions have on sight. How would your daily activities be impacted? What moments would you lose? Whose faces would you miss? Try our vision simulator by visiting https://bcbsfepvision.com/visionsimulator.

Virtual Frame Try-on
Description: Our frame try-on tool allows you to try our Exclusive Collection frames from the convenience of your phone, tablet, or computer. Use your webcam to see what the frames look like on you or you can select a model. Try our virtual frame try-on tool by visiting https://bcbsfepvision.com/frametryon.

AskBlue BCBS FEP Vision Plan Finder
Description: 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 https://askblue.bcbsfepvision.com

Member Portal
Description: Visit our member portal at www.bcbsfepvision.com/portal to, view your benefits, locate an in-network provider, check the status of your claims, request claim forms, and request a duplicate or replacement ID card. Additional features include:

- Online EOBs – You can view, download, and print your Explanation of Benefits (EOB) forms. Simply log on to www.bcbsfepvision.com/portal, enter your credentials, and from there you can search claims and select the "EOB" link next to each claim to access your EOB. You can also access EOBs via the bcbsfepvision mobile app.
- Check eligibility – You can verify all the eligible members on your account.
- Submit an out-of-network claim – If you choose to see an out-of-network provider you can submit your claim online in the member portal or via the bcbsfepvision mobile app.
- Shop online retailers – You can access our online retail partners' websites by clicking on the retailer's name.

BCBS FEP Vision Mobile Application
Description: BCBS FEP Vision'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 BCBS FEP Vision benefits. They can log in with their username and password to access personal eye care 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, locate in-network providers and shop online retailers.

Social Media
Description: Follow us @fepblue on Facebook, Instagram, YouTube and LinkedIn for the latest information happening at BCBS FEP Vision.

Virtual Experience
Description: We're thrilled to offer a unique, one-of-a-kind virtual experience! Don't miss this engaging, entertaining and educational experience for you to explore more about our vision care plans. View this virtual experience on your computer or mobile device by going to https://bcbsfepvision.com/experience/.

Section 6 International Services and Supplies

If you travel or live outside the United States and Puerto Rico, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this section, the same definitions, limitations, and exclusions also apply.

Please note that pre-authorization does not apply when you receive care outside of the United States and Puerto Rico. You or your provider must submit an explanation of medical necessity for the services listed in Section 3, How You Obtain Care, when you receive these services outside of the United States and Puerto Rico.

International Claims Payment

For professional care you receive overseas, we provide benefits as indicated below. You are responsible for any difference between our payment and the amount billed, in addition to any copayment amounts. You must also pay any charges for non-covered services.

Finding an International Provider

We do not maintain a network of providers outside the United States and Puerto Rico. You may visit any international provider of your choice and be reimbursed up to the amount listed under "International Plan Allowances" below.

Filing International Claims

International providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim along with an itemized receipt to us for reimbursement.** Claim forms are available at www.bcbsfepvision.com or via email at fepmemberhelp@davisvision.com. To file a claim for covered vision care services received outside the United States and Puerto Rico, send completed claim forms and itemized receipts to:

Blue Cross Blue Shield FEP Vision
PO Box 507
Troy, NY 12181

Or you may fax your claim to 518-220-6555. Please contact us at fepmemberhelp@davisvision.com to let us know you would like to submit your claim via email. We will respond with instructions on how to securely submit your claim.

Customer Service Website and Phone Numbers

Contact us at: www.bcbsfepvision.com, via email at fepmemberhelp@davisvision.com or at 1-518-220-6569, TTY: 1-800-523-2847.

International Plan Allowances

You may need to pay the provider in-full at the time of service and you will be reimbursed up to the amounts shown below:

Services/Material: Vision Care Exam
High Option: We pay up to $60
Standard Option: We pay up to $60

Services/Material: Single Vision Lenses
High Option: We pay up to $72
Standard Option: We pay up to $72

Services/Material: Bifocal Lenses
High Option: We pay up to $109
Standard Option: We pay up to $109

Services/Material: Trifocal Lenses
High Option: We pay up to $136
Standard Option: We pay up to $136

Services/Material: Lenticular Lenses
High Option: We pay up to $136
Standard Option: We pay up to $136

Services/Material: Contact Lenses
High Option: We pay up to $150
Standard Option: We pay up to $140

Services/Material: Medically Necessary Contact Lenses
High Option: We pay up to $600
Standard Option: We pay up to $600

Services/Material: Frames
High Option: We pay up to $200
Standard Option: We pay up to $140

Section 7 General Exclusions – Things We Do Not Cover

The exclusions in this section apply to all benefits.

We do not cover the following:

- Services provided by non-participating providers for Standard Option members;
- Any charges in excess of the benefit, dollar, or supply limits stated in this brochure;
- Any vision service, treatment or materials not specifically listed as a covered service;
- Any exams given during your stay in a hospital or other facility for medical care;
- Drugs or medicines;
- Services and materials that are experimental or investigational;
- Services or materials that are rendered prior to your effective date;
- Services and materials incurred after the termination date of your coverage unless otherwise indicated;
- Services and materials not meeting accepted standards of optometric practice;
- Services and materials resulting from your failure to comply with professionally prescribed treatment;
- Benefits may not be combined with any discount or promotional offering unless otherwise noted in an offer;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services or materials provided as a result of intentionally self-inflicted injury or illness;
- Services or materials 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 any costs associated with forwarding/mailing copies of your records or charts;
- State or territorial taxes on vision services and materials;
- Medical treatment of eye disease or injury;
- Special vision procedures, such as orthoptics, vision therapy or vision training;
- Special lens designs or coatings other than those described in this brochure;
- Special supplies such as nonprescription sunglasses and subnormal vision aids;
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals;
- Services not performed by licensed personnel;
- Prosthetic devices and services or digital devices such as iPads, cell phones, etc.
- Insurance of contact lenses;
- Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, sibling, by blood, marriage or adoption;
- Deductibles, copayments and coinsurance for medical services or other insurance are not reimbursable.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

If your vision care provider is participating in our network, they will file the claim for you, and we will send payment directly to the vision care provider.

If you live in a limited access area, overseas or if you obtain services from a non-participating provider (High Option only), you are responsible for filing the claim. You can submit your out-of-network claim electronically using the mobile app, member portal on our website, or you can obtain claim forms on the website at

www.bcbsfepvision.com or by calling 1-888-550-BLUE (2583) or TTY: 1-800-523-2847.

You can also submit an out-of-network claim form along with copies of the provider's bills by mail to:

Blue Cross Blue Shield FEP Vision
PO Box 507
Troy, NY 12181

Deadline for Filing Your Claim

Out-of-network claims (High Option only), international claims, and claims incurred in limited access areas must be submitted to and received by BCBS FEP Vision within 12 months of the date of service for reimbursement.

Disputed Claims Process

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

Disputed Claim Steps:

1. Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and
b) Send your request to us at the address shown below; and
c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
d) Include copies of documents that support your claim, such as doctor's letters, and Explanation of Benefits (EOB) forms.

Blue Cross Blue Shield FEP Vision
PO Box 507
Troy, NY 12181

FAX: 1-800-403-1783
Email: fepmemberhelp@davisvision.com

2. We have 30 days from the date we receive your request to:

a) Pay the claim or
b) Write to you and maintain our denial or
c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. If the dispute is not resolved through the reconsideration process, you may request a review of the denial. We will make a decision within 35 days of the date we receive your request in writing.

4. If you do not agree with our final decision, you may request an independent third party, mutually agreed upon by us and OPM, review the decision. The decision of the independent third party is binding on us and is the final administrative review of your claim. This decision is not subject to judicial review.

Section 9 Definitions of Terms We Use in This Brochure

Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Enrollee	The Federal employee, annuitant, or TRICARE-eligible individual enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Plan Allowance	The maximum benefit payment for services received. Please refer to Section 4, Your Cost for Covered Services, for the maximum benefit payment for services received in limited access areas or out-of-network and Section 6, International Services and Supplies, for services received outside the United States or Puerto Rico.
Pre-Authorization	This is the procedure used by BCBS FEP Vision to pre-approve services and the amount that BCBS FEP Vision will cover.
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).
TRICARE-eligible individual (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, and under age 23 if they are a full-time student or incapable of self-support because of a mental or physical incapacity.
We/Us	Blue Cross Blue Shield FEP Vision.
You	Enrollee or eligible family member.

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 BCBS FEP Vision identification (ID) number over the telephone or to people you do not know, except to your providers, plan, BENEFEDS or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your Explanation of Benefits (EOBs) statements, which are available online at www.bcbsfepvision.com.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-888-550-BLUE (2583) or TTY: 1-800-523-2847 and explain the situation.
- **Federal Civilians -** 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
  - 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 or incapable of self-support)
  - Your child over age 23 if they are enrolled in school (unless they are disabled or 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.

Summary of Benefits

- **Do not rely on this summary alone**. This page summarizes specific expenses we cover; for more detail, please review the individual sections of this brochure.
- We offer additional benefits for children age 13 and under as well as members with specific conditions (e.g., diabetes, hypertension) see full details in Section 5.
- We offer an additional $50 frame allowance if you utilize a MyEyeDr. location.
- If you want to enroll or change your enrollment in this plan, please visit www.BENEFEDS.gov or call 1-877-888-FEDS (3337), TTY number 1-877-889-5680.
- We offer retinal imaging at a $29 copay for both High Option and Standard Option.

Covered Services In-Network
Vision Care Exams (a comprehensive exam that focuses on your eye health and overall wellness)
High Option: You pay nothing
Standard Option: You pay nothing
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Standard Eyeglass Lenses (Contact lenses may be obtained in lieu of glasses)
High Option: You pay nothing.
Standard Option: You pay $10
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Optional Lenses and Treatments
High Option: You pay nothing for Transitions®, Polycarbonate Lenses, Standard Progressives Lenses, Tinted Lenses, Ultraviolet Protective Coating. Some additional copays apply to other lens treatments.
Standard Option: You pay nothing for Polycarbonate Lenses, Tinted Lenses, Ultraviolet Protective Coating. Some additional copays apply to other lens treatments.
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Frame Allowance - Collection Frames
High Option: You pay nothing
Standard Option: You pay nothing
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Frame Allowance
High Option: You pay any amount over the $200 Plan allowance after a 20% discount. **At MyEyeDr. you pay any amount over $250** frame allowance. 20% discount does not apply.
Standard Option: You pay any amount over the $140 Plan allowance after a 20% discount. **At MyEyeDr. you pay any amount over $190** frame allowance. 20% discount does not apply.
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Contact Lenses
High Option: You pay any amount over the $150 Plan allowance after a 15% discount. For Non-Specialty contact lenses the Evaluation, Fitting and Follow-up care are covered in full at network providers. For Specialty lenses you receive a $60 allowance at in-network providers.
Standard Option: You pay any amount over the $140 Plan allowance after a 15% discount. For Non-Specialty contact lenses the Evaluation, Fitting and Follow-up care you pay a $55 copay at in-network providers.
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Laser Vision Correction
High Option: You pay the provider's charge after the negotiated discount
Standard Option: You pay the provider's charge after the negotiated discount.

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See Section 4, Your Cost for Covered Services, for the Out-of-Network benefits available under High Option. See Section 5, Vision Services and Supplies for complete benefit information

Rate Information

High - Bi-Weekly			High - Monthly		
Self Only	**Self Plus One**	**Self and Family**	**Self Only**	**Self Plus One**	**Self and Family**
$5.66	**$11.31**	**$16.97**	**$12.26**	**$24.51**	**$36.77**

Standard - Bi-Weekly			Standard - Monthly		
Self Only	**Self Plus One**	**Self and Family**	**Self Only**	**Self Plus One**	**Self and Family**
$3.56	**$7.12**	**$10.68**	**$7.71**	**$15.43**	**$23.14**