UnitedHealthcare Dental Plan

www.myuhcdental.com/fedvip

1-866-315-2321 or TTY 711

United Healthcare

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
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Enrollment Options for this Plan:

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

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

FEDVIP
Federal Employees
Dental And Vision Insurance Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The law directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants, and their eligible family members. In response to the legislation, OPM established the Federal Employees Dental and Vision Insurance Program (FEDVIP). OPM has contracted with dental and vision insurers to offer an array of choices to Federal employees and annuitants. Section 715 of the National Defense Authorization Act for Fiscal Year 2017 (FY 2017 NDAA), Public Law 114-38,expanded FEDVIP eligibility to certain TRICARE-eligible individuals.

This brochure describes the benefits of UnitedHealthcare Dental Plan under UnitedHealthcare Dental Plan's contract OPM02-FEDVIP-02AP-15 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

UnitedHealthcare Dental
10175 Little Patuxent Parkway
6th Floor
Columbia, MD 21044
1-866-315-2321 or TTY 711
www.myuhcdental.com/fedvip

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.

UnitedHealthcare Dental Plan is responsible for the selection of in-network providers in your area. Contact us at 1-866-315-2321 or TTY 711 - for the names of participating providers. You may view the most current directory via our website at www.myuhcdental.com/fedvip. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided, not for 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 may nominate him or her to join. Nomination forms are available on our web site, or call us and we will have a form sent to you. You cannot change plans outside of open season because of changes to the provider network.

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

This UnitedHealthcare Dental 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 at www.myuhcdental.com/fedvip, and then click on the "Legal and Privacy Notices" 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 1-866-315-2321 or TTY 711.

Discrimination is Against the Law
UnitedHealthcare 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, UnitedHealthcare 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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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 can 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 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 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.

Changes for 2025

The following CDT Codes have been added for both High and Standard Options:

Class C: D6180 Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments

Class C: D6193 Replacement of an implant screw

Class D: D8091 Comprehensive orthodontic treatment with orthognathic surgery

Class D: D8671 Periodic orthodontic treatment visit associated with orthognathic surgery

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

Advise BENEFEDS of your new payroll office number.

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, an unremarried former spouse who meets the U.S Department of Defense's 20-20-20 or 20-20-15 eligibility requirements, 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 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 (1-877-888-3337), TTY number 1-877-889-5680 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not want to change plans, your enrollment will continue automatically. Please Note: Your plans' premiums may change for 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.

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee, annuitant, or TRICARE-eligible individual, you may enroll in a dental and/or vision plan during the November 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; or
- an employee returning to service following a break in service of at least 31 days.
- a TRICARE-eligible individual

Qualifying Life Event

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

The following chart lists the QLEs and the enrollment actions you may take.

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

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

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

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

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

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

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

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

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

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

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

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 a 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.

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 1-877-888-3337, TTY number 1-877-889-5680.

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

When Coverage Stops

- no longer meet the definition of an eligible employee, annuitant, or TRICARE-eligible individual;
- as a Retired Reservist you begin active duty;
- as sponsor or primary enrollee leaves active duty;
- begin a period of non-pay status or pay that is insufficient to have your FEDVIP premiums withheld and you do not make direct premium payments to BENEFEDS;
- are making direct premium payments to BENEFEDS and you stop making the payments;
- cancel the enrollment during open season;
- a Retired Reservist begins active duty; or
- the sponsor or primary enrollee leaves active duty.

• Coverage for a family member ends when:

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

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

Continuation of Coverage

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

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

FSAFEDS/High Deductible Health Plans and FEDVIP

If you are 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	Enroll online at www.BENEFEDS.gov. Upon confirmation of your enrollment, you will be sent a welcome packet with a new member checklist. Your UnitedHealthcare Dental Plan identification card is available electronically at www.myuhc.com if you have a UnitedHealthcare Medical Plan or www.myuhcdental.com/fedvip if you do not have a UnitedHealthcare Medical Plan. You may contact customer service at 1-866-315-2321 or TTY 711 for a physical card to mailed to your home address.
Where You Get Covered Care	You may visit any provider in the UnitedHealthcare Dental network. Log on to www.myuhcdental.com/fedvip and select the provider locator option. You may also contact UnitedHealthcare Dental's 24-hour, toll-free Interactive Voice Response (IVR) system dedicated to Federal employees and annuitants at 1-866-315-2321 or TTY 711. You may elect to visit any dental provider to utilize your benefit, even if they are not part of the UnitedHealthcare Dental provider network.
Plan Providers	We list plan providers on our Web site at www.myuhcdental.com/fedvip. In addition, you can call UnitedHealthcare Dental Plan's 24-hour, toll-free Interactive Voice Response (IVR) system dedicated to Federal employees and annuitants at 1-866-315-2321 or TTY 711.
In-Network	Once you locate an in-network provider, call the provider directly to schedule your appointment. Identify yourself as having UnitedHealthcare Dental coverage and provide the primary insured's subscriber number and patient's name and date of birth. You can find participating providers at www.myuhcdental.com/fedvip.
Out-of-Network	If you use a dentist outside the network, you may need to pay the difference between what the plan covers and what your dentist charges for the services. Plus, you may need to submit your own claims to the following address: UnitedHealthcare Dental Attention: Claims Department P.O. Box 30567 Salt Lake City, UT 84130-0567
Emergency Services	All expenses for emergency services are payable as any other expense, subject to plan provisions. If you receive emergency services from an out-of-network dentist, benefits will be paid under the out-of-network plan provisions. You are responsible for the difference between the maximum allowed amount and the billed charge.
Maximum Amount Allowed	The maximum amount of reimbursement we allow for a specific procedure. When you use an in-network provider, the provider cannot bill you for the difference between the Maximum Allowed Amount and the billed charge. When you use an out-of-network provider, you are responsible for the difference between the Maximum Allowed Amount and the billed charge in addition to applicable coinsurance and deductible amounts.
Precertification	You and your dentist may request us to precertify dental procedures that your dentist plans to perform. We will provide an explanation of benefits to both you and your dentist that will indicate if procedures are covered and what we will pay for those specific services.
Alternate Benefit	If more than one service or procedure can be used to treat the covered person's dental condition, UnitedHealthcare Dental may decide to authorize coverage only for the less costly covered service or procedure when that service is an appropriate method of treatment and the service meets broadly accepted national standards of dental practice. For example, this may apply but not limited to include: an amalgam or composite filling may be the alternate benefit of a crown or; a partial denture may be an alternate benefit for implants. Should the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond the allowance for the alternate service, even if an in-network provider.

Dental Review

UnitedHealthcare Dental Plan's claim review is conducted by licensed dental professionals who review the clinical documentation submitted by your treating dentist. These licensed dental professionals review the records checking for dental necessity for certain procedures such as crowns, bridges, onlays, implants, periodontal treatments, as well as other services. The licensed dental professionals may also recommend that an alternate benefit be applied to a service in accordance with the terms of the plan.

FEHB/PSHB First Payor

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. The FEDVIP plan allowance will be the prevailing charge in these cases. You are responsible for the difference between the FEHB/PSHB and FEDVIP benefit payments and the FEDVIP plan allowance. UnitedHealthcare Dental is responsible for facilitating the process with the FEHB/PSHB first payor. It is important to bring your FEDVIP and FEHB/PSHB identification cards to every dental appointment to ensure that you are receiving the maximum allowable benefit under each program.

Coordination of Benefits

If you are covered under a non-FEHB/non-PSHB plan, your UnitedHealthcare 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.

Here is an example of how we would coordinate benefits if a non-FEHB/non-PSHB plan was primary. This example assumes all deductibles have been met and annual maximums have not been reached. The amounts listed in the chart below are for example purposes only and do not reflect your non-FEHB/non-PSHB or UnitedHealthcare Dental benefits. The example does not include your copay which you are responsible for paying.

UnitedHealthcare Dental coverage is secondary to non-FEHB/non-PSHB coverage

In-Network Dentist's Fee: $200.00*

Plan Allowance: $150.00

Primary Plan's Scheduled Amount: $125.00

Primary Plan's Payment: $125.00

FEDVIP Payment: $25.00 ($150.00-$125.00)

Member Payment: $0.00

*You are not responsible for the $50.00 difference between the dentist’s fee and the plan allowance, when you use an in-network dentist. The dentist cannot bill you for this amount.

Rating Areas

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

Limited Access Area

If you live in a limited access area* (defined as driving distance greater than 15 miles urban areas/ greater than 35 miles in rural areas) and you receive covered dental services from an out-of-network provider, we will pay the same plan allowances as if you utilized an in-network provider. It is important to note that you will be responsible for the difference between the billed amount and our payment. If you have any questions about limited access areas or you are having problems locating an in-network dentist in your area, please call us at 1-866-315-2321 or TTY 711

***NOTE: Access Standards**

Limited Access does not apply to International Members.

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

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

Section 4 Your Cost For Covered Services

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

Deductible

A deductible is a fixed amount of expenses you must incur for certain covered services and supplies before we will pay for covered services. 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: $0
Out-of-Network Standard Option: $100 (Self), $200 (Self Plus One), $300(Family)

Class B
In-Network High Option: $0
In-Network Standard Option: $0
Out-of-Network High Option: $50 (Self), $100 (Self Plus One), $150 (Family)
Out-of-Network Standard Option: $100 (Self), $200 (Self Plus One), $300(Family)

Class C
In-Network High Option: $0
In-Network Standard Option: $0
Out-of-Network High Option: $50 (Self), $100 (Self Plus One), $150 (Family)
Out-of-Network Standard Option: $100 (Self), $200 (Self Plus One), $300(Family)

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: 10%

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

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

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

Annual Benefit Maximum	Once you reach this amount, you are responsible for all additional charges. The Annual Benefit Maximums within each option are combined between in and out-of-network services. The total Annual Benefit Maximum will never be greater than the In-Network Maximum Annual Benefit. **Maximum Annual Benefits:** In-Network High Option: Unlimited In-Network Standard Option: $1,500 per person Out-of-Network High Option: $3,000 per person Out-of-Network Standard Option: $1,000 per person
Lifetime Benefit Maximum	The Lifetime Maximum is applicable to Orthodontia benefits only. The Lifetime Maximums within each option are combined between in and out-of-network services. There are no other lifetime maximums under this Plan. **Lifetime Orthodontic Maximum** In-Network High Option: $2,000 per adult / $4,000 per child* In-Network Standard Option: $2,000 per person Out-of-Network High Option: $2,000 per adult / $4,000 per child* Out-of-Network Standard Option: $2,000 person *Child is defined as ages 18 and under.
In-Network Services	You pay the coinsurance percentage of our network allowance for covered services. You are not responsible for charges above that allowance.
Out-of-Network Services	If the dentist you use is not part of our network, benefits will be considered at the out-of-network level. All services provided by an out-of-network dentist will be paid at out-of-network levels, except for limited access benefits. All benefit payments are based on UnitedHealthcare Dental's Plan Allowance Amounts, which is a schedule of fixed dollar maximums established by UnitedHealthcare Dental for services by out-of-network providers. If a member chooses to go out of network, payments will be made directly to the member.
Calendar Year	The calendar year refers to the plan year, which is defined as January 1, 2025 to December 31, 2025.
Emergency Services	Emergency services are defined as those dental services needed to relieve pain or prevent the worsening of a condition that would be caused by a delay.
In-Progress Treatment	In-progress treatment for dependents of retiring active duty service members who were enrolled in the TRICARE Dental Program (TDP) will be covered for the 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.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is $0 if you use an in-network provider. If you elect to use an out-of-network provider, the Standard Option has deductible amounts of $100 for Self, $200 for Self Plus One, and $300 for Family for Class A, B, and C services; High Option has deductible amounts of $50 for Self, $100 for Self Plus One, and $150 for Family for Class B and C services.
- The Annual Benefit Maximums within each option are combined between in and out-of-network services. The total Annual Benefit Maximum will never be greater than the in-network Maximum Annual Benefit. The Standard Option Annual Benefit Maximum is $1,500 per person for in-network services or $1,000 per person for out-of-network services for Class A, B, and C services. The High Option does not have Annual Benefit Maximums for in-network services and has an Annual Benefit Maximum of $3,000 per person for out-of-network services for Class A, B, and C services.
- The frequencies between your FEHB/PSHB and UnitedHealthcare Dental policy are combined not separate. (ex. If 2 oral exams are covered under your FEHB/PSHB policy, and 2 oral exams are covered under UnitedHealthcare Dental a total of 2 oral exams will be covered and coverage will coordinate between both policies)
- All Exams, oral evaluations and treatments such as fluorides and some images are combined under one limitation under the plan. D0210 Intraoral – comprehensive series of radiographic images and / or D0330 Panoramic radiographic image are combined and limited to one every 60 months. D0120 Periodic oral evaluation - established patient, D0140 Limited oral evaluation - problem focused, 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 two exams per calendar year.
- All services requiring more than one visit are payable once all visits are completed.
- The following list is an all-inclusive list of covered services. UnitedHealthcare Dental will provide benefits for these services, subject to the exclusions and limitations shown in this section and Section 7.
- Included with your plan benefits is comprehensive coverage for various methods of annual oral cancer screenings for all adults. In addition included in your plan is a Supplemental Oral Cancer Benefit. Any UnitedHealthcare Dental member who receives a diagnosis of Oral, Head and Neck Cancer, and who has an impact to their teeth and supporting structures, is eligible for a one-time single lump sum payment of $2,000 to cover expenses such as lost wages, child care, and more. This added financial benefit can be used at the member's discretion as they navigate the various demands this diagnosis may bring. This is a fixed oral cancer benefit to aid with the unexpected dental care and personal disruptions often bringing an added financial burden.
- Any dental service or treatment not listed as a covered service is not eligible for benefits.

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 – After deductible, you pay 10% of the plan allowance, subject to plan maximums. You are responsible for the difference between the plan payment and the amount billed by the provider.

Standard 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 - After deductible, you pay 10% of the plan allowance, subject to plan maximums. You are responsible for the difference between the plan payment and the amount billed by the provider.

Diagnostic and Treatment Services

D0120 Periodic oral evaluation - established patient - *Limited to 2 times per calendar year*

D0140 Limited oral evaluation - problem focused - *Limited to 2 times per calendar year*

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver - *Limited to 2 times per calendar year*

D0150 Comprehensive oral evaluation - new or established patient - *Limited to 2 times per calendar year*

D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit) - *Limited to 2 times per calendar year*

D0180 Comprehensive periodontal evaluation - new or established patient - *Limited to 2 times per calendar year*

D0210 Intraoral – comprehensive series of radiographic images – *Limited to 1 per 60 months*

D0220 Intraoral - periapical first radiographic image - *Limited to 8 images per calendar year*

D0230 Intraoral - periapical each additional radiographic image - *Limited to 8 images per calendar year*

D0240 Intraoral - occlusal radiographic image - *Limited to 4 images per calendar year*

D0250 Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector - *Limited to 2 images per calendar year*

D0251 Extra-oral posterior dental radiographic image - *Limited to 2 images per calendar year*

D0270 Bitewing - single radiographic image – *Limited to 1 series of images per calendar year*

D0272 Bitewings - two radiographic images - *Limited to 1 series of images per calendar year*

D0273 Bitewings - three radiographic images - *Limited to 1 series of images per calendar year*

D0274 Bitewings - four radiographic images - *Limited to 1 series of images per calendar year*

D0277 Vertical bitewings - 7 to 8 radiographic images - *Limited to 1 series of images per calendar year*

D0330 Panoramic radiographic image - *Limited to 1 complete series or a panoramic radiographic image per 60 months.*

D0350 2D oral/facial photographic image obtained intra-orally or extra-orally - *Limited to 1 time per consecutive 36 months*

D0391 Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report

D0414 Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report

D0415 Collection of microorganisms for culture and sensitivity

D0416 Viral culture

D0422 Collection and preparation of genetic sample material for laboratory analysis and report - *Limited to 1 per 60 months*

D0423 Genetic test for susceptibility to diseases – specimen analysis - *Limited to 1 per 60 months*

D0425 Caries susceptibility tests - *Limited to 1 per 60 months*

D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures – *Limited to 1 time per calendar year for adults*

D0460 Pulp vitality tests - *Limited to 1 charge per visit, regardless of how many teeth are tested.*

D0470 Diagnostic casts - *Limited to 1 time per consecutive 24 months*

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report

D0600 Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum - *Limited to 1 per 36 months*

Diagnostic and Treatment Services - continued on next page

Diagnostic and Treatment Services (cont.)
D0601 Caries risk assessment and documentation, with a finding of low risk - *Limited to 2 times per calendar year*
D0602 Caries risk assessment and documentation, with a finding of moderate risk - *Limited to 2 times per calendar year*
D0603 Caries risk assessment and documentation, with a finding of high risk - *Limited to 2 times per calendar year*
D9995 Teledentistry - synchronous; real-time encounter - *Limited to 2 times per calendar year*
D9996 Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review - *Limited to 2 times per calendar year*
Preventive Services
D1110 Prophylaxis - adult - (Age 13 and under will be processed as D1120 Prophylaxis - child) - *Limited to 2 times per calendar year*
D1120 Prophylaxis - child - (Age 14 and over will be processed as D1110 Prophylaxis - adult) - *Limited to 2 times per calendar year*
D1206 Topical application of fluoride varnish - *Limited to 2 times per calendar year*
D1208 Topical application of fluoride – excluding varnish - *Limited to 2 times per calendar year*
D1351 Sealant - per tooth - *Limited to covered persons under the age of 19 years and once per first or second permanent molar every consecutive 36 months*
D1352 Preventive resin restoration in a moderate to high caries risk patient – permanent tooth - *Limited to covered persons under the age of 19 years and once per first or second permanent molar every consecutive 36 months*
D1353 Sealant repair – per tooth - *Limited to covered persons under the age of 19 years and once per first or second permanent molar every 36 months*
D1354 Application of caries arresting medicament – per tooth - *Limited per permanent (molars & premolars) tooth per 36 months, excludes wisdom teeth*
D1510 Space maintainer - fixed, unilateral – per quadrant - *Limited to covered persons under the age of 19 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation*
D1516 Space maintainer – fixed – bilateral, maxillary - *Limited to covered persons under the age of 19 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation*
D1517 Space maintainer – fixed – bilateral, mandibular - *Limited to covered persons under the age of 19 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation*
D1520 Space maintainer - removable, unilateral - per quadrant - *Limited to covered persons under the age of 19 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation*
D1526 Space maintainer – removable – bilateral, maxillary - *Limited to covered persons under the age of 19 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation*
D1527 Space maintainer – removable – bilateral, mandibular - *Limited to covered persons under the age of 19 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation*
D1551 Re-cement or re-bond bilateral space maintainer – maxillary - *Limited to 1 per consecutive 6 months after initial insertion*
D1552 Re-cement or re-bond bilateral space maintainer - mandibular - *Limited to 1 per consecutive 6 months after initial insertion*
D1553 Re-cement or re-bond unilateral space maintainer – per quadrant - *Limited to 1 per consecutive 6 months after initial insertion*
D1556 Removal of fixed unilateral space maintainer - per quadrant
D1557 Removal of fixed bilateral space maintainer - maxillary
D1558 Removal of fixed bilateral space maintainer - mandibular
D1575 Distal shoe space maintainer - fixed, unilateral - per quadrant - *Limited to covered persons under the age of 19 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation*
D9110 Palliative treatment of dental pain – per visit - *Covered as a separate benefit only if no other services, other than exam and radiographs were done on the same tooth during the visit*
D9440 Office visit - after regularly scheduled hours - *Limited to 1 per calendar year. Subject to clinical review and necessity*

Services Not Covered

Refer to Section 7 for a list of general exclusions

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is $0 if you use an in-network provider. If you elect to use an out-of-network provider, the Standard Option has deductible amounts of $100 for Self, $200 for Self Plus One, and $300 for Family for Class A, B, and C services; High Option has deductible amounts of $50 for Self, $100 for Self Plus One, and $150 for Family for Class B and C services.
- The Annual Benefit Maximums within each option are combined between in and out-of-network services. The total Annual Benefit Maximum will never be greater than the in-network Maximum Annual Benefit. The Standard Option Annual Benefit Maximum is $1,500 per person for in-network services or $1,000 per person for out-of-network services for Class A, B, and C services. The High Option does not have Annual Benefit Maximums for in-network services and has an Annual Benefit Maximum of $3,000 per person for out-of-network services for Class A, B, and C services.
- The frequencies between your FEHB/PSHB and UnitedHealthcare Dental policy are combined not separate. (ex. If 2 oral exams are covered under your FEHB/PSHB policy, and 2 oral exams are covered under UnitedHealthcare Dental a total of 2 oral exams will be covered and coverage will coordinate between both policies).
- If more than one service or procedure can be used to treat the covered person's dental condition, UnitedHealthcare Dental may decide to authorize coverage only for the less costly covered service or procedure when that service is an appropriate method of treatment and the service meets broadly accepted national standards of dental practice. This may apply but not limited to include: an amalgam or composite filling may be the alternate benefit of a crown or, a partial denture may be an alternate benefit for implants. Should the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond the allowance for the alternate service, even if an in-network provider.
- All services requiring more than one visit are payable once all visits are completed.
- Amalgam/Resin - Multiple restorations on one surface will be treated as a single filling.
- D2391 Resin-based composite - one surface, posterior, D2392 Resin-based composite - two surfaces, posterior, D2393 Resin-based composite - three surfaces, posterior and D2394 Resin-based composite - four or more surfaces, posterior - Alternate benefitting for molars only.
- The following list is an all-inclusive list of covered services. UnitedHealthcare Dental will provide benefits for these services, subject to the exclusions and limitations shown in this section and Section 7.
- Included with your plan benefits is comprehensive coverage for various methods of annual oral cancer screenings for all adults. In addition included in your plan is a Supplemental Oral Cancer Benefit. Any UnitedHealthcare Dental member who receives a diagnosis of Oral, Head and Neck Cancer, and who has an impact to their teeth and supporting structures, is eligible for a one-time single lump sum payment of $2,000 to cover expenses such as lost wages, child care, and more. This added financial benefit can be used at the member's discretion as they navigate the various demands this diagnosis may bring. This is a fixed oral cancer benefit to aid with the unexpected dental care and personal disruptions often bringing an added financial burden.
- Any dental service or treatment not listed as a covered service is not eligible for benefits.

You Pay:

High Option

- **In-Network:** 30% for covered services as defined by the plan subject to plan maximums.

		• **Out-of-Network:** After deductible, you pay 40% of the plan allowance, subject to plan maximums. You are responsible for the difference between the plan payment and the amount billed by the provider. **Standard Option** • **In-Network:** 45% for covered services as defined by the plan subject to plan maximums. • **Out-of-Network:** After deductible, you pay 60% of the plan allowance, subject to plan maximums. You are responsible for the difference between the plan payment and the amount billed by the provider.	

Minor Restorative Services

D2140 Amalgam – one surface, primary or permanent

D2150 Amalgam – two surfaces, primary or permanent

D2160 Amalgam – three surfaces, primary or permanent

D2161 Amalgam – four or more surfaces, primary or permanent

D2330 Resin-based composite – one surface, anterior

D2331 Resin-based composite – two surfaces, anterior

D2332 Resin-based composite – three surfaces, anterior

D2335 Resin-based composite – four or more surfaces (anterior)

D2390 Resin-based composite crown, anterior

D2391 Resin-based composite – one surface, posterior

D2392 Resin-based composite – two surfaces, posterior

D2393 Resin-based composite – three surfaces, posterior

D2394 Resin-based composite – four or more surfaces, posterior

D2610 Inlay - porcelain/ceramic - one surface - *Limited to 1 time per tooth per consecutive 60 months*

D2620 Inlay - porcelain/ceramic - two surfaces - *Limited to 1 time per tooth per consecutive 60 months.*

D2630 Inlay - porcelain/ceramic - three or more surfaces - *Limited to 1 time per tooth per consecutive 60 months.*

D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration - *Limited to 1 per consecutive 12 months. Limited to those performed more than 12 months after the initial insertion*

D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core - *Limited to 1 per consecutive 12 months. Limited to those performed more than 12 months after the initial insertion*

D2920 Re-cement or re-bond crown - *Limited to 1 per consecutive 12 months. Limited to those performed more than 12 months after the initial insertion*

D2921 Reattachment of tooth fragment, incisal edge or cusp – *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.*

D2929 Prefabricated porcelain/ceramic crown – primary tooth – *Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. D2934 Prefabricated esthetic coated stainless steel crown - primary tooth are limited to primary anterior teeth*

D2930 Prefabricated stainless steel crown - primary tooth – *Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. D2934 Prefabricated esthetic coated stainless steel crown - primary tooth are limited to primary anterior teeth.*

D2931 Prefabricated stainless steel crown – permanent tooth – *Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.*

D2940 Placement of interim direct restoration - *Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit*

D2951 Pin retention – per tooth, in addition to restoration - *Limited to 2 pins per tooth; not Covered in addition to cast restoration. Limited to 1 time per consecutive 60 months.*

D2989 Excavation of a tooth resulting in the determination of non-restorability

Endodontic Services
D3110 Pulp cap - direct (excluding final restoration) - *Not Covered if utilized solely as a liner or base underneath a restoration*
D3120 Pulp cap - indirect (excluding final restoration) - *Not Covered if utilized solely as a liner or base underneath a restoration*
D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament - *Limited to 1 time per primary or secondary tooth per lifetime*
D3221 Pulpal debridement, primary and permanent teeth - *Limited to 1 time per tooth per lifetime. Not covered on the same day as other endodontic services*
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development - *Limited to 1 time per primary or secondary tooth per lifetime.*
D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) - *Limited to 1 per tooth per lifetime.*
D3240 Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) - *Limited to 1 per tooth per lifetime.*
D3331 Treatment of root canal obstruction; non-surgical access - *Limited to 1 time per tooth per lifetime*
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth - *Limited to 1 time per tooth per lifetime*
D3333 Internal root repair of perforation defects - *Limited to 1 time per tooth per lifetime*
D3355 Pulpal regeneration - initial visit - *Limited to 1 time per tooth per lifetime*
D3356 Pulpal regeneration - interim medication replacement - *Limited to 1 time per tooth per lifetime*
D3357 Pulpal regeneration - completion of treatment - *Limited to 1 time per tooth per lifetime*
D3430 Retrograde filling - per root - *Limited to 1 time per tooth per lifetime*
Periodontal Services
D4230 Anatomical crown exposure – four or more contiguous teeth or tooth bounded spaces per quadrant - *Limited to 1 per quadrant or site per consecutive 36 months*
D4231 Anatomical crown exposure – one to three teeth or tooth bounded spaces per quadrant - *Limited to 1 per quadrant or site per consecutive 36 months*
D4245 Apically positioned flap - *Limited to 1 per quadrant or site per consecutive 36 months*
D4264 Bone replacement graft – retained natural tooth – each additional site in quadrant - *Limited to 1 per consecutive 36 months. (For D4263 Bone replacement graft – retained natural tooth – first site in quadrant see Class C services.)*
D4265 Biologic materials to aid in soft and osseous tissue regeneration, per site - *Limited to 1 per consecutive 36 months*
D4266 Guided tissue regeneration, natural teeth – resorbable barrier, per site - *Limited to 1 per consecutive 36 months*
D4267 Guided tissue regeneration, natural teeth – non-resorbable barrier, per site - *Limited to 1 per consecutive 36 months*
D4268 Surgical revision procedure, per tooth - *Limited to 1 per quadrant or site per consecutive 36 months. (For D4263 Bone replacement graft – retained natural tooth – first site in quadrant see Class C services.)*
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)
D4276 Combined connective tissue and pedicle graft, per tooth - *Limited to 1 per quadrant or site per consecutive 36 months*
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft - *Limited to 1 per quadrant or site per consecutive 36 months*
D4341 Periodontal scaling and root planing - four or more teeth per quadrant - *Limited to 1 time per quadrant per consecutive 24 months*
D4342 Periodontal scaling and root planing - one to three teeth per quadrant – *Limited to 1 time per quadrant per consecutive 24 months.*
D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *Limited to 2 times per calendar year in combination with prophylaxis and periodontal maintenance*

Periodontal Services - continued on next page

Periodontal Services (cont.)
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - *Limited to 3 sites per quadrant or 12 sites total for refractory pockets or in conjunction with Periodontal Scaling and Root Planing*
D4910 Periodontal maintenance - *Limited to the maximum of 4 per calendar year in combination with adult prophylaxis and scaling in presence of generalized moderate or severe gingival inflammation*
D4920 Unscheduled dressing change (by someone other than treating dentist or their staff) - *Limited to 1 per consecutive 6 months, Limited to 1 per day*
D4999 Unspecified periodontal procedure, by report - *Subject to clinical review and necessity.*
Prosthodontic Services
D5410 Adjust complete denture – maxillary - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5411 Adjust complete denture – mandibular - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5421 Adjust partial denture – maxillary - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5422 Adjust partial denture – mandibular - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5511 Repair broken complete denture base, mandibular - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5512 Repair broken complete denture base, maxillary - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5520 Replace missing or broken teeth – complete denture – per tooth - *Limit 1 beginning 6 months after the initial installation*
D5611 Repair resin partial denture base, mandibular - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5612 Repair resin partial denture base, maxillary - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5621 Repair cast partial framework, mandibular - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5622 Repair cast partial framework, maxillary - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5630 Repair or replace broken retentive clasping materials - per tooth - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5640 Replace missing or broken teeth – partial denture – per tooth - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5650 Add tooth to existing partial denture – per tooth - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5660 Add clasp to existing partial denture - per tooth - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5670 Replace all teeth and acrylic on cast metal framework (maxillary) – *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5671 Replace all teeth and acrylic on cast metal framework (mandibular) – *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D5710 Rebase complete maxillary denture – *Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 36 months*
D5711 Rebase complete mandibular denture – *Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 36 months*
D5720 Rebase maxillary partial denture – *Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 36 months*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D5721 Rebase mandibular partial denture - *Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 36 months*
D5730 Reline complete maxillary denture (direct) – *Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 36 months*
D5731 Reline complete mandibular denture (direct) - *Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 36 months*
D5740 Reline maxillary partial denture (direct) – *Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 36 months*
D5741 Reline mandibular partial denture (direct) – *Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 36 months*
D5750 Reline complete maxillary denture (indirect) – *Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 36 months*
D5751 Reline complete mandibular denture (indirect) – *Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 36 months*
D5760 Reline maxillary partial denture (indirect) – *Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 36 months*
D5761 Reline mandibular partial denture (indirect) – *Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 36 months*
D5850 Tissue conditioning, maxillary - *Limited to 1 time per consecutive 12 months*
D5851 Tissue conditioning, mandibular - *Limited to 1 time per consecutive 12 months*
D6092 Re-cement or re-bond implant/abutment supported crown - *Limited to 1 time per consecutive 6 months*
D6093 Re-cement or re-bond implant/abutment supported fixed partial denture - *Limited to 1 time per consecutive 6 months*
D6930 Re-cement or re-bond fixed partial denture - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.*
D6980 Fixed partial denture repair necessitated by restorative material failure - *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.*
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
D7260 Oroantral fistula closure - *Limited to one per site per visit*
D7261 Primary closure of a sinus perforation - *Limited to 1 time per tooth per lifetime*
D7270 Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth - *Limited to 1 per site per lifetime*
D7272 Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization) - *Limited to 1 per site per lifetime*
D7280 Exposure of an unerupted tooth - *Limited to 1 per tooth per lifetime*
D7282 Mobilization of erupted or malpositioned tooth to aid eruption - *Limited to 1 per tooth per lifetime*
D7283 Placement of device to facilitate eruption of impacted tooth - *Limited to 1 per tooth per lifetime*

Oral Surgery - continued on next page

Oral Surgery (cont.)
D7285 Incisional biopsy of oral tissue-hard (bone, tooth) - *Limited to 1 per site per visit*
D7286 Incisional biopsy of oral tissue-soft - *Limited to 1 per site per visit*
D7287 Exfoliative cytological sample collection – *Limited to 1 per site per visit*
D7288 Brush biopsy - transepithelial sample collection - *Limited to 1 per site per visit*
D7291 Transseptal fiberotomy/supra crestal fiberotomy, by report - *Limited to 1 per tooth per lifetime*
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
D7410 Excision of benign lesion up to 1.25 cm - *Limited to 1 per site per visit*
D7411 Excision of benign lesion greater than 1.25 cm - *Limited to 1 per site per visit*
D7412 Excision of benign lesion, complicated - *Limited to 1 per site per visit*
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm - *Limited to 1 per site per visit*
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm - *Limited to 1 per site per visit*
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm - *Limited to 1 per site per visit*
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm - *Limited to 1 per site per visit*
D7471 Removal of lateral exostosis (maxilla or mandible) - *Limited to 1 per site per visit*
D7510 Incision and drainage of abscess – intraoral soft tissue - *Limited to 1 per site per visit*
D7511 Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) - *Limited to 1 per site per visit*
D7520 Incision and drainage of abscess - extraoral soft tissue - *Limited to 1 per site per visit*
D7521 Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) - *Limited to 1 per site per visit*
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue - *Limited to 1 per site per visit*
D7540 Removal of reaction producing foreign bodies, musculoskeletal system - *Limited to 1 per site per visit*
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone - *Limited to 1 per site per visit*
D7910 Suture of recent small wounds up to 5 cm - *Limited to 1 per site per visit*
D7921 Collection and application of autologous blood concentrate product – *Limited to 1 per consecutive 36 months*
D7953 Bone replacement graft for ridge preservation - per site – *Limited to 1 per site per lifetime. Not covered if done in conjunction with other bone graft replacement procedures.*
D7963 Frenuloplasty
D7970 Excision of hyperplastic tissue - per arch - *Limited to 1 site per consecutive 36 months*
D7971 Excision of pericoronal gingiva - *Limited to 1 site per consecutive 36 months*
D7972 Surgical reduction of fibrous tuberosity – *Limited to 1 site per consecutive 36 months*
D7997 Appliance removal (not by dentist who placed appliance), includes removal of archbar - *Limited to once per appliance per lifetime*
D7999 Unspecified oral surgery procedure, by report - *Subject to clinical review and necessity.*

Other Services
D9210 Local anesthesia not in conjunction with operative or surgical procedures - *Not Covered in conjunction with operative or surgical procedure – Limited to 1 time per tooth per consecutive 60 months*
D9219 Evaluation for moderate sedation, deep sedation or general anesthesia - *Covered when Necessary in conjunction with covered dental services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically necessary. Covered for patients over age of 6 if it is clinically necessary.*
D9230 Inhalation of nitrous oxide/analgesia, anxiolysis - *Covered when Necessary in conjunction with covered dental services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically necessary. Covered for patients over age of 6 if it is clinically necessary.*
D9248 Non-intravenous conscious sedation - *Covered when Necessary in conjunction with covered dental services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically necessary. Covered for patients over age of 6 if it is clinically necessary.*
D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician - *Not covered if done with exams or professional visit*
D9612 Therapeutic parenteral drugs, two or more administrations, different medications - *Limited to 1 per visit*
D9630 Drugs or medicaments dispensed in the office for home use - *Limited to 1 per site per 6 months*
D9910 Application of desensitizing medicament - *Limited to 1 per site per 6 months*
D9911 Application of desensitizing resin for cervical and/or root surface, per tooth - *Limited to 1 per site per 6 months*
D9950 Occlusion analysis - mounted case - *Limited to 1 time per consecutive 60 months*
D9951 Occlusal adjustment – limited - *Limited to 1 per site per 6 months*
D9952 Occlusal adjustment – complete - *Limited to 1 per site per 6 months*
Services Not Covered
Refer to Section 7 for a list of general exclusions

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is $0 if you use an in-network provider. If you elect to use an out-of-network provider, the Standard Option has deductible amounts of $100 for Self, $200 for Self Plus One, and $300 for Family for Class A, B, and C services; High Option has deductible amounts of $50 for Self, $100 for Self Plus One, and $150 for Family for Class B and C services.
- The Annual Benefit Maximums within each option are combined between in and out-of-network services. The total Annual Benefit Maximum will never be greater than the in-network Maximum Annual Benefit. The Standard Option Annual Benefit Maximum is $1,500 per person for in-network services or $1,000 per person for out-of-network services for Class A, B, and C services. The High Option does not have Annual Benefit Maximums for in-network services and has an Annual Benefit Maximum of $3,000 per person for out-of-network services for Class A, B, and C services.
- If more than one service or procedure can be used to treat the covered person's dental condition, UnitedHealthcare Dental may decide to authorize coverage only for the less costly covered service or procedure when that service is an appropriate method of treatment and the service meets broadly accepted national standards of dental practice. This may apply but not limited to include: an amalgam or composite filling may be the alternate benefit of a crown or, a partial denture may be an alternate benefit for implants. Should the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond the allowance for the alternate service, even if an in-network provider.
- All services requiring more than one visit are payable once all visits are completed.
- The following list is an all-inclusive list of covered services. UnitedHealthcare Dental will provide benefits for these services, subject to the exclusions and limitations shown in this section and Section 7.
- Included with your plan benefits is comprehensive coverage for various methods of annual oral cancer screenings for all adults. In addition included in your plan is a Supplemental Oral Cancer Benefit. Any UnitedHealthcare Dental member who receives a diagnosis of Oral, Head and Neck Cancer, and who has an impact to their teeth and supporting structures, is eligible for a one-time single lump sum payment of $2,000 to cover expenses such as lost wages, child care, and more. This added financial benefit can be used at the member's discretion as they navigate the various demands this diagnosis may bring. This is a fixed oral cancer benefit to aid with the unexpected dental care and personal disruptions often bringing an added financial burden.
- Any dental service or treatment not listed as a covered service is not eligible for benefits.

You Pay:

High Option

- **In-Network:** No deductible; you pay 50% of the plan allowance for covered services as defined by the plan.
- **Out-of-Network:** After deductible, you pay 60% of the plan allowance for covered services as defined by the plan 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.
- **Out-of-Network:** After 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
D2410 Gold foil – one surface – *Multiple restorations on one surface will be treated as a single filling*
D2420 Gold foil – two surfaces – *Multiple restorations on one surface will be treated as a single filling*
D2430 Gold foil – three surfaces – *Multiple restorations on one surface will be treated as a single filling*
D2510 Inlay - metallic - one surface - *Limited to 1 time per tooth per consecutive 60 months.*
D2520 Inlay - metallic - two surfaces - *Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.*
D2530 Inlay - metallic - three or more surfaces – *Limited to 1 per tooth per 60 consecutive months.*
D2542 Onlay - metallic - two surfaces – *Limited to 1 per tooth per consecutive 60 months*
D2543 Onlay - metallic - three surfaces – *Limited to 1 per tooth per consecutive 60 months*
D2544 Onlay - metallic - four or more surfaces – *Limited to 1 per tooth per consecutive 60 months*
D2642 Onlay - porcelain/ceramic - two surfaces – *Limited to 1 per tooth per consecutive 60 months, including crowns, bridges, prosthetics*
D2643 Onlay - porcelain/ceramic - three surfaces – *Limited to 1 per tooth per consecutive 60 months, including crowns, bridges, prosthetics*
D2644 Onlay - porcelain/ceramic - four or more surfaces – *Limited to 1 per tooth per consecutive 60 months, including crowns, bridges, prosthetics*
D2650 Inlay - resin-based composite - one surface – *Limited to 1 per tooth per consecutive 60 months*
D2651 Inlay - resin-based composite - two surfaces – *Limited to 1 per tooth per consecutive 60 months*
D2652 Inlay - resin-based composite - three or more surfaces – *Limited to 1 per tooth per consecutive 60 months*
D2662 Onlay - resin-based composite - two surfaces – *Limited to 1 per tooth per consecutive 60 months*
D2663 Onlay - resin-based composite - three surfaces – *Limited to 1 per tooth per consecutive 60 months*
D2664 Onlay - resin-based composite - four or more surfaces – *Limited to 1 per tooth per consecutive 60 months*
D2710 Crown - resin-based composite (indirect) – *Limited to 1 per tooth per consecutive 60 months*
D2712 Crown - ¾ resin-based composite (indirect) – *Limited to 1 per tooth per consecutive 60 months*
D2720 Crown - resin with high noble metal – *Limited to 1 per tooth per consecutive 60 months*
D2721 Crown - resin with predominantly base metal – *Limited to 1 per tooth per consecutive 60 months*
D2722 Crown - resin with noble metal – *Limited to 1 per tooth per consecutive 60 months*
D2740 Crown - porcelain/ceramic – *Limited to 1 per tooth per consecutive 60 months*
D2750 Crown - porcelain fused to high noble metal – *Limited to 1 per tooth per consecutive 60 months*
D2751 Crown - porcelain fused to predominantly base metal – *Limited to 1 per tooth per consecutive 60 months*
D2752 Crown - porcelain fused to noble metal – *Limited to 1 per tooth per consecutive 60 months*
D2753 Crown - porcelain fused to titanium and titanium alloys – *Limited to 1 time per tooth per consecutive 60 months*
D2780 Crown - 3/4 cast high noble metal - *Limited to 1 per tooth per consecutive 60 months*
D2781 Crown - 3/4 cast predominantly base metal – *Limited to 1 per tooth per consecutive 60 months*
D2782 Crown - 3/4 cast noble metal – *Limited to 1 per tooth per consecutive 60 months*
D2783 Crown - 3/4 porcelain/ceramic – *Limited to 1 per tooth per consecutive 60 months*
D2790 Crown - full cast high noble metal – *Limited to 1 per tooth per consecutive 60 months*
D2791 Crown - full cast predominantly base metal – *Limited to 1 per tooth per consecutive 60 months*
D2792 Crown - full cast noble metal – *Limited to 1 per tooth per consecutive 60 months*
D2794 Crown - titanium and titanium alloys - *Limited to 1 per tooth per consecutive 60 months*
D2932 Prefabricated resin crown - *Limited to 1 per tooth per consecutive 60 months*
D2933 Prefabricated stainless steel crown with resin window – *Limited to 1 per tooth per consecutive 60 months*
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth – *Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. D2934 Prefabricated esthetic coated stainless steel crown - primary tooth are limited to primary anterior teeth*

Major Restorative Services - continued on next page

Major Restorative Services (cont.)
D2950 Core buildup, including any pins when required – *Limited to 1 per tooth per consecutive 60 months when there is significant loss of tooth structure and deemed Necessary based on clinical review*
D2952 Post and core in addition to crown, indirectly fabricated – *Covered only for teeth that have had root canal therapy. Limited to 1 per tooth per consecutive 60 months*
D2953 Each additional indirectly fabricated post - same tooth – *Covered only for teeth that have had root canal therapy. Limited to 1 per tooth per consecutive 60 months*
D2954 Prefabricated post and core in addition to crown – *Covered only for teeth that have had root canal therapy. Limited to 1 per tooth per consecutive 60 months*
D2957 Each additional prefabricated post - same tooth
D2960 Labial veneer (resin laminate) - direct - *Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth*
D2961 Labial veneer (resin laminate) - indirect - *Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth*
D2962 Labial veneer (porcelain laminate) - indirect - *Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth*
D2975 Coping - *Limited to 1 per tooth per consecutive 60 months*
D2980 Crown repair necessitated by restorative material failure – *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D2981 Inlay repair necessitated by restorative material failure - *Limit 1 every 12 months- Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D2982 Onlay repair necessitated by restorative material failure – *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D2983 Veneer repair necessitated by restorative material failure – *Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months*
D2990 Resin infiltration of incipient smooth surface lesions - *Limited to 1 per consecutive 36 months*
Endodontic Services
D3310 Endodontic therapy, anterior tooth (excluding final restoration) - *Limited to 1 time per tooth per lifetime. Dentist cannot charge retreatment codes on tooth treated for the first 12 months.*
D3320 Endodontic therapy, premolar tooth (excluding final restoration) - *Limited to 1 time per tooth per lifetime. Dentist cannot charge retreatment codes on tooth treated for the first 12 months.*
D3330 Endodontic therapy, molar tooth (excluding final restoration) - *Limited to 1 time per tooth per lifetime. Dentist cannot charge retreatment codes on tooth treated for the first 12 months.*
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.) - *Limited to 1 per tooth per lifetime*
D3352 Apexification/recalcification – interim medication replacement - *Limited to 1 per tooth per lifetime*
D3353 Apexification/recalcification – final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) - *Limited to 1 per tooth per lifetime*
D3410 Apicoectomy - anterior - *Limited to 1 per tooth per lifetime*
D3421 Apicoectomy - premolar (first root) - *Limited to 1 per tooth per lifetime*
D3425 Apicoectomy - molar (first root) - *Limited to 1 per tooth per lifetime*
D3426 Apicoectomy (each additional root) - *Limited to 1 per tooth per lifetime*
D3450 Root amputation – per root - *Limited to 1 per tooth per lifetime*
D3920 Hemisection (including any root removal), not including root canal therapy - *Limited to 1 per tooth per lifetime*

Periodontal Services

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant – *Limited to 1 per quadrant or site per consecutive 36 months*

D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant – *Limited to 1 per quadrant or site per consecutive 36 months*

D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth – *Limited to 1 per quadrant or site per consecutive 36 months*

D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant – *Limited to 1 per quadrant or site per consecutive 36 months*

D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant – *Limited to 1 per quadrant or site consecutive 36 months*

D4249 Clinical crown lengthening – hard tissue – *Limited to 1 per quadrant or site per consecutive 36 months*

D4260 Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant – *Limited to 1 per consecutive 36 months*

D4261 Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant – *Limited to 1 per consecutive 36 months*

D4263 Bone replacement graft – retained natural tooth – first site in quadrant - *Limited to 1 per consecutive 36 months. (For D4264 Bone replacement graft – retained natural tooth – each additional site in quadrant and D4268 Surgical revision procedure, per tooth see Class B services.)*

D4270 Pedicle soft tissue graft procedure – *Limited to 1 per quadrant or site per consecutive 36 months*

D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft – *Limited to 1 per quadrant or site per consecutive 36 months*

D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft - *Limited to 1 per quadrant or site per consecutive 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 – *Limited to 1 per quadrant or site per consecutive 36 months. (For D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft see Class B services.)*

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 – *Limited to 1 per quadrant or site per consecutive 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 – *Limited to 1 per quadrant or site per consecutive 36 months*

D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - *Limited to 1 per consecutive 36 months*

Prosthodontic Services

D5110 Complete denture – maxillary – *Limited to 1 per consecutive 60 months*

D5120 Complete denture - mandibular – *Limited to 1 per consecutive 60 months*

D5130 Immediate denture – maxillary – *Limited to 1 per consecutive 60 months*

D5140 Immediate denture - mandibular – *Limited to 1 per consecutive 60 months*

D5211 Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth) – *Limited to 1 per consecutive 60 months*

D5212 Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth) – *Limited to 1 per consecutive 60 months*

D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) – *Limited to 1 per consecutive 60 months*

D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) – *Limited to 1 per consecutive 60 months*

D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) – *Limited to 1 per consecutive 60 months*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) – *Limited to 1 per consecutive 60 months*
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) - *Limited to 1 per consecutive 60 months*
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) - *Limited to 1 per consecutive 60 months*
D5225 Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) – *Limited to 1 per consecutive 60 months*
D5226 Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) – *Limited to 1 per consecutive 60 months*
D5282 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary – *Limited to 1 per consecutive 60 months*
D5283 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular - *Limited to 1 per consecutive 60 months*
D5284 Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant – *Limited to 1 per consecutive 60 months*
D5286 Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant – *Limited to 1 per consecutive 60 months*
D5810 Interim complete denture (maxillary) - *Limited to 1 per consecutive 60 months*
D5811 Interim complete denture (mandibular) - *Limited to 1 per consecutive 60 months*
D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - *Limited to 1 per consecutive 60 months*
D5821 Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - *Limited to 1 per consecutive 60 months*
D5863 Overdenture – complete maxillary - *Limited to 1 per consecutive 60 months*
D5864 Overdenture – partial maxillary - *Limited to 1 per consecutive 60 months*
D5865 Overdenture – complete mandibular - *Limited to 1 per consecutive 60 months*
D5866 Overdenture – partial mandibular - *Limited to 1 per consecutive 60 months*
D5876 Add metal substructure to acrylic full denture (per arch) - *Limited to 1 per consecutive 60 months*
D6010 Surgical placement of implant body: endosteal implant – *Limited to 1 per tooth per consecutive 60 months*
D6012 Surgical placement of interim implant body for transitional prosthesis: endosteal implant – *Limited to 1 per tooth per consecutive 60 months*
D6013 Surgical placement of mini implant – *Limited to 1 per tooth per consecutive 60 months*
D6040 Surgical placement: eposteal implant – *Limited to 1 per tooth per consecutive 60 months*
D6050 Surgical placement: transosteal implant – *Limited to 1 per tooth per consecutive 60 months*
D6055 Connecting bar – implant supported or abutment supported - *Limited to 1 time per tooth per consecutive 60 months*
D6056 Prefabricated abutment - includes modification and placement – *Limited to 1 time per tooth per consecutive 60 months*
D6057 Custom fabricated abutment – includes placement - *Limited to 1 time per tooth per consecutive 60 months*
D6058 Abutment supported porcelain/ceramic crown – *Limited to 1 time per tooth per consecutive 60 months*
D6059 Abutment supported porcelain fused to metal crown (high noble metal) - *Limited to 1 time per tooth per consecutive 60 months*
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal) - *Limited to 1 time per tooth per consecutive 60 months*
D6061 Abutment supported porcelain fused to metal crown (noble metal) - *Limited to 1 time per tooth per consecutive 60 months*
D6062 Abutment supported cast metal crown (high noble metal) - *Limited to 1 time per tooth per consecutive 60 months*
D6063 Abutment supported cast metal crown (predominantly base metal) – *Limited to 1 time per tooth per consecutive 60 months*
D6064 Abutment supported cast metal crown (noble metal) – *Limited to 1 time per tooth per consecutive 60 months*
D6065 Implant supported porcelain/ceramic crown – *Limited to 1 time per tooth per consecutive 60 months*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6066 Implant supported crown - porcelain fused to high noble alloys – *Limited to 1 time per tooth per consecutive 60 months*
D6067 Implant supported crown - high noble alloys – *Limited to 1 time per tooth per consecutive 60 months*
D6068 Abutment supported retainer for porcelain/ceramic FPD – *Limited to 1 time per tooth per consecutive 60 months*
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal) – *Limited to 1 time per tooth per consecutive 60 months*
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) – *Limited to 1 time per tooth per consecutive 60 months*
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal) – *Limited to 1 time per tooth per consecutive 60 months*
D6072 Abutment supported retainer for cast metal FPD (high noble metal) – *Limited to 1 time per tooth per consecutive 60 months*
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal) - *Limited to 1 time per tooth per consecutive 60 months*
D6074 Abutment supported retainer for cast metal FPD (noble metal) - *Limited to 1 time per tooth per consecutive 60 months*
D6075 Implant supported retainer for ceramic FPD – *Limited to 1 time per tooth per consecutive 60 months*
D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6077 Implant supported retainer for metal FPD - high noble alloys – *Limited to 1 time per tooth per consecutive 60 months*
D6080 Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments – *Limited to 1 time per tooth per consecutive 60 months*
D6081 Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure – *Limited to 1 time per tooth per consecutive 60 months*
D6082 Implant supported crown – porcelain fused to predominantly base alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6083 Implant supported crown – porcelain fused to noble alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6084 Implant supported crown – porcelain fused to titanium and titanium alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6086 Implant supported crown – predominantly base alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6087 Implant supported crown – noble alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6088 Implant supported crown – titanium and titanium alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6089 Accessing and retorquing loose implant screw - per screw
D6090 Repair of implant/abutment supported prosthesis – *Limited to 1 time per tooth per consecutive 60 months*
D6091 Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment – *Limited to 1 time per tooth per consecutive 60 months*
D6094 Abutment supported crown - titanium and titanium alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6096 Remove broken implant retaining screw – *Limited to 1 time per consecutive 12 months*
D6097 Abutment supported crown – porcelain fused to titanium and titanium alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6098 Implant supported retainer – porcelain fused to predominantly base alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6099 Implant supported retainer for FPD – porcelain fused to noble alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6100 Surgical removal of implant body – *Limited to 1 time per tooth per consecutive 60 months*
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 – *Limited to 1 time per consecutive 60 months*
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 – *Limited to 1 time per consecutive 60 months*
D6103 Bone graft for repair of peri-implant defect – does not include flap entry and closure - *Limited to 1 time per consecutive 36 months*
D6104 Bone graft at time of implant placement - *Limited to 1 time per consecutive 36 months*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6110 Implant /abutment supported removable denture for edentulous arch – maxillary - *Limited to 1 time per tooth per consecutive 60 months*
D6111 Implant /abutment supported removable denture for edentulous arch – mandibular - *Limited to 1 time per tooth per consecutive 60 months*
D6112 Implant /abutment supported removable denture for partially edentulous arch – maxillary - *Limited to 1 time per tooth per consecutive 60 months*
D6113 Implant /abutment supported removable denture for partially edentulous arch – mandibular - *Limited to 1 time per tooth per consecutive 60 months*
D6114 Implant /abutment supported fixed denture for edentulous arch – maxillary - *Limited to 1 time per tooth per consecutive 60 months*
D6115 Implant /abutment supported fixed denture for edentulous arch – mandibular - *Limited to 1 time per tooth per consecutive 60 months*
D6116 Implant /abutment supported fixed denture for partially edentulous arch – maxillary - *Limited to 1 time per tooth per consecutive 60 months*
D6117 Implant /abutment supported fixed denture for partially edentulous arch – mandibular - *Limited to 1 time per tooth per consecutive 60 months*
D6120 Implant supported retainer – porcelain fused to titanium and titanium alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6121 Implant supported retainer for metal FPD – predominantly base alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6122 Implant supported retainer for metal FPD – noble alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6123 Implant supported retainer for metal FPD – titanium and titanium alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6180 Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments
D6190 Radiographic/surgical implant index, by report – *Limited to 1 time per tooth per consecutive 60 months*
D6193 Replacement of an implant screw
D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6195 Abutment supported retainer – porcelain fused to titanium and titanium alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6205 Pontic – indirect resin based composite – *Limited to 1 time per tooth per consecutive 60 months*
D6210 Pontic - cast high noble metal - *Limited to 1 time per tooth per consecutive 60 months*
D6211 Pontic - cast predominantly base metal - *Limited to 1 time per tooth per consecutive 60 months*
D6212 Pontic - cast noble metal - *Limited to 1 time per tooth per consecutive 60 months*
D6214 Pontic - titanium and titanium alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6240 Pontic - porcelain fused to high noble metal - *Limited to 1 time per tooth per consecutive 60 months*
D6241 Pontic - porcelain fused to predominantly base metal - *Limited to 1 time per tooth per consecutive 60 months*
D6242 Pontic - porcelain fused to noble metal - *Limited to 1 time per tooth per consecutive 60 months*
D6243 Pontic – porcelain fused to titanium and titanium alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6245 Pontic - porcelain/ceramic - *Limited to 1 time per tooth per consecutive 60 months*
D6250 Pontic – resin with high noble metal – *Limited to 1 time per tooth per consecutive 60 months*
D6251 Pontic - resin with predominantly base metal – *Limited to 1 time per tooth per consecutive 60 months*
D6252 Pontic - resin with noble metal - *Limited to 1 time per tooth per consecutive 60 months*
D6545 Retainer - cast metal for resin bonded fixed prosthesis - *Limited to 1 time per tooth per consecutive 60 months*
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis - *Limited to 1 time per tooth per consecutive 60 months*
D6549 Retainer – resin bonded fixed prosthesis - *Limit 1 every 60 months, including all other crowns, bridges, prosthetics*
D6600 Retainer inlay - porcelain/ceramic, two surfaces - *Limited to 1 time per tooth per consecutive 60 months*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces - *Limited to 1 time per tooth per consecutive 60 months*
D6602 Retainer inlay - cast high noble metal, two surfaces – *Limited to 1 time per tooth per consecutive 60 months*
D6603 Retainer inlay - cast high noble metal, three or more surfaces – *Limited to 1 time per tooth per consecutive 60 months*
D6604 Retainer inlay - cast predominantly base metal, two surfaces - *Limited to 1 time per tooth per consecutive 60 months*
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces - *Limited to 1 time per tooth per consecutive 60 months*
D6606 Retainer inlay - cast noble metal, two surfaces – *Limited to 1 time per tooth per consecutive 60 months*
D6607 Retainer inlay - cast noble metal, three or more surfaces – *Limited to 1 time per tooth per consecutive 60 months*
D6608 Retainer onlay - porcelain/ceramic, two surfaces - *Limited to 1 time per tooth per consecutive 60 months*
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces - *Limited to 1 time per tooth per consecutive 60 months including all other crowns, bridges, prosthetics*
D6610 Retainer onlay - cast high noble metal, two surfaces – *Limited to 1 time per tooth per consecutive 60 months*
D6611 Retainer onlay - cast high noble metal, three or more surfaces – *Limited to 1 time per tooth per consecutive 60 months*
D6612 Retainer onlay - cast predominantly base metal, two surfaces – *Limited to 1 time per tooth per consecutive 60 months*
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces – *Limited to 1 time per tooth per consecutive 60 months*
D6614 Retainer onlay - cast noble metal, two surfaces – *Limited to 1 time per tooth per consecutive 60 months*
D6615 Retainer onlay - cast noble metal, three or more surfaces – *Limited to 1 time per tooth per consecutive 60 months*
D6624 Retainer inlay - titanium – *Limited to 1 time per tooth per consecutive 60 months*
D6634 Retainer onlay - titanium – *Limited to 1 time per tooth per consecutive 60 months*
D6710 Retainer crown - indirect resin based composite - *Limited to 1 time per tooth per consecutive 60 months*
D6720 Retainer crown - resin with high noble metal - *Limited to 1 time per tooth per consecutive 60 months*
D6721 Retainer crown - resin with predominantly base metal - *Limited to 1 time per tooth per consecutive 60 months*
D6722 Retainer crown - resin with noble metal – *Limited to 1 time per tooth per consecutive 60 months*
D6740 Retainer crown - porcelain/ceramic – *Limited to 1 time per tooth per consecutive 60 months*
D6750 Retainer crown - porcelain fused to high noble metal - *Limited to 1 time per tooth per consecutive 60 months*
D6751 Retainer crown - porcelain fused to predominantly base metal – *Limited to 1 time per tooth per consecutive 60 months*
D6752 Retainer crown - porcelain fused to noble metal - *Limited to 1 time per tooth per consecutive 60 months*
D6753 Retainer crown – porcelain fused to titanium and titanium alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6780 Retainer crown - 3/4 cast high noble metal - *Limited to 1 time per tooth per consecutive 60 months*
D6781 Retainer crown - 3/4 cast predominantly base metal - *Limited to 1 time per tooth per consecutive 60 months*
D6782 Retainer crown - 3/4 cast noble metal – *Limited to 1 time per tooth per consecutive 60 months*
D6783 Retainer crown - 3/4 porcelain/ceramic – *Limited to 1 time per tooth per consecutive 60 months*
D6784 Retainer crown 3/4 – titanium and titanium alloys - *Limited to 1 time per tooth per consecutive 60 months*
D6790 Retainer crown - full cast high noble metal - *Limited to 1 time per tooth per consecutive 60 months*
D6791 Retainer crown - full cast predominantly base metal - *Limited to 1 time per tooth per consecutive 60 months*
D6792 Retainer crown - full cast noble metal - *Limited to 1 time per tooth per consecutive 60 months*
D6793 Interim retainer crown - further treatment or completion of diagnosis necessary prior to final impression - *Limited to 1 time per tooth per consecutive 60 months*
D6794 Retainer crown - titanium and titanium alloys - *Limited to 1 time per tooth per consecutive 60 months*
D9120 Fixed partial denture sectioning – *Limited to 1 time per tooth per consecutive 60 months*
D9941 Fabrication of athletic mouthguard
D9943 Occlusal guard adjustment - *Limit 1 every 24 months*
D9944 Occlusal guard – hard appliance, full arch – *Limited to 1 per consecutive 36 months*
D9945 Occlusal guard – soft appliance, full arch – *Limited to 1 per consecutive 36 months*
D9946 Occlusal guard – hard appliance, partial arch – *Limited to 1 per consecutive 36 months*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D9999 Unspecified adjunctive procedure, by report – *Covered if Necessary*
Other Services
D0160 Detailed and extensive oral evaluation - problem focused, by report - *Limited to 2 times per calendar year*
D9222 Deep sedation/general anesthesia – first 15 minutes – *Covered when Necessary*
D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment - *Covered when Necessary*
D9239 Intravenous moderate (conscious) sedation/analgesia – first 15 minutes - *Covered when Necessary*
D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment - *Covered when Necessary*
D9610 Therapeutic parenteral drug, single administration
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report
D9974 Internal bleaching - per tooth
Services Not Covered
Refer to Section 7 for a list of general exclusions

Class D Orthodontic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no deductible.
- We pay 50% of the plan allowance up to the lifetime maximum. If you are covered by the High Option the lifetime maximum for orthodontic services is up to $2,000 per adult and $4,000 per child*. If you are enrolled in the Standard Option the lifetime maximum for orthodontic services is up to $2,000 per person.
- Any dental service or treatment not listed as a covered service is not eligible for benefits.

*Child is defined as 18 and under.

You Pay:

High Option

- **In-Network:** 50% of the plan allowance up to the $2,000 per adult and $4,000 per child lifetime maximum. You are responsible for all charges that exceed the lifetime maximum.
- **Out-of-Network:** 50% of the plan allowance up to the $2,000 per adult and $4,000 per child lifetime maximum and any difference between our allowance and the billed amount.

Standard Option

- **In-Network:** 50% of the plan allowance up to the $2,000 per person lifetime maximum. You are responsible for all charges that exceed the lifetime maximum.
- **Out-of-Network:** 50% of the plan allowance up to the $2,000 per person lifetime maximum and any difference between our allowance and the billed amount.

Orthodontic Services

D0340 2D cephalometric radiographic image – acquisition, measurement and analysis – *Limited to 1 per consecutive 12 months*
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
D8091 Comprehensive orthodontic treatment with orthognathic surgery
D8210 Removable appliance therapy - *Limited to 1 time per consecutive 60 months*
D8220 Fixed appliance therapy - *Limited to 1 time per consecutive 60 months*
D8660 Pre-orthodontic treatment examination to monitor growth and development - *Limited to new patients or 2 times per consecutive 12 months*
D8670 Periodic orthodontic treatment visit
D8671 Periodic orthodontic treatment visit associated with orthognathic surgery
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)) - *Limited to 1 time per consecutive 60 months*
D8695 Removal of fixed orthodontic appliances for reasons other than completion of treatment – *Limited to 1 time per consecutive 60 months.*
D8698 Re-cement or re-bond fixed retainer – maxillary
D8699 Re-cement or re-bond fixed retainer – mandibular

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 used exclusively to alter vertical dimension and/or restore or maintain the occlusion.

Section 6 International Services and Supplies

International Claims Payment	If you receive dental services while overseas, you will pay the provider in-full at the time of service. You will then need to submit the claim to UnitedHealthcare Dental. Upon receipt of the claim we will translate the claim if necessary and process it. We use the rate of exchange in effect at the time we process the claim. Claims are paid in U.S. currency.
Finding an International Provider	You may use any dentist while overseas.
Filing International Claims	Submit the itemized paid receipt(s), along with the primary insured's unique identification number and patient's name and date of birth to: SCS RMO-Lason Inc 4050 South 500 West, Ste 50 Salt Lake City, UT 84123-1358 Attn: 224 - Foreign Claims - DBP
International Rates	There is one international region. Please see the rate table for the actual premium amount.

Section 7 General Exclusions – Things We Do Not Cover

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

We do not cover the following:

- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of their license and applicable state law;
- Services and treatment which are experimental or investigational;
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
- Services and treatment performed prior to your effective date of coverage;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice;
- Services and treatment resulting from your failure to comply with professionally prescribed treatment;
- Any charges for failure to keep a scheduled appointment;
- Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- State or territorial taxes on dental services performed;
- Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;
- Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- Those for which the member would have no obligation to pay in the absence of this or any similar coverage;
- Those which are for specialized procedures and techniques;
- Those performed by a dentist who is compensated by a facility for similar covered services performed for members;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;

- Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- Charges by the provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Cone Beam Imaging and Cone Beam MRI procedures;
- Sealants for teeth other than permanent molars are not covered;
- 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;
- Fabrication of athletic mouth guard;
- Topical medicament center;
- Bone grafts when done in connection with extractions, apicoectomies or non-covered/non-eligible implants;
- Restoration foundation for an indirect restoration;
- Veneers for cosmetic purposes;
- Blood glucose level test - in-office using a glucose meter;
- Temporomandibular joint dysfunction – non-invasive physical therapies;
- Infiltration of sustained release therapeutic drug – single or multiple sites;
- Duplicate/copy patient's records;
- When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other service) as determined by UnitedHealthcare Dental.
- When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by this plan.
- Incomplete Endodontic Therapy, inoperable, unrestorable or fractured tooth is not a covered service.
- All out-of-network services listed in Section 5 are subject to the maximum allowable amount as defined by UnitedHealthcare Dental. The member is responsible for all remaining charges that exceed the allowable maximum.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

To avoid delay in the payment of your dental claims, please have your dental provider submit your claims directly to your FEHB/PSHB plan (Should you be enrolled), then to UnitedHealthcare Dental. Pretreatment estimates can be submitted directly to UnitedHealthcare Dental (exception: If accidental injury occurs, pretreatment estimates should be submitted to your FEHB/PSHB plan).

If you need to send in a paper claim you may download a claim form from UnitedHealthcare Dental's website, www.myuhcdental.com/fedvip.

Mail completed claim form to:

UnitedHealthcare Dental
Attention: Claims Department
P.O. Box 30567
Salt Lake City, UT 84130-0567

Deadline for Filing Your Claim

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

Disputed Claims Process

Step 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 180 days from the date of receipt of our decision.

Step 2:

You may mail your request for reconsideration to:

UnitedHealthcare Dental
Attention: Dental Appeals and Grievance
P.O. Box 30569
Salt Lake City, UT 84130-0569

Or go to www.myuhcdental.com/fedvip

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.

Step 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 receipt of our reconsideration. 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. We will provide a decision within 30 days of receipt of your request for second review.

Step 4:

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

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

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

Section 9 Definitions of Terms We Use in This Brochure

Alternative Benefit	If we determine a service less costly than the one performed by your dentist could have been performed by your dentist, we will pay benefits based upon the less costly services. See Section 3, How You Obtain Care.
Annual Benefit Maximum	The maximum annual benefit that you can receive per person.
Annuitants	Federal retirees (who retired on an immediate annuity) and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Calendar Year	From January 1, 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 X-rays.
Class B Services	Intermediate services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
Class C Services	Major services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
Class D Services	Orthodontic services.
Date of Service	The calendar date on which you visit the dentist's office and services are rendered.
Enrollee	The Federal employee, annuitant, or TRICARE-eligible individual enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Generally Accepted Dental Protocols	Dental Necessity means that a dental service or treatment is performed in accordance with generally accepted dental standards, as determined from multiple sources including but not limited to relevant clinical dental research from various research organizations including dental schools, current recognized dental school standard of care curriculums and organized dental groups including the American Dental Association, which is necessary to treat decay, disease or injury of teeth, or essential for the care of teeth and supporting tissues of the teeth.
In-Progress Treatment	Dental services that initiated in 2024 that will be completed in 2025.
Maximum Allowed Amount	The amount we use to determine our payment for services. If services are provided by an in-network dentist the maximum allowable amount is based on the discounted fee they accept as payment in full for the procedure or procedures. If services are provided by an out-of- network dentist the maximum allowed amount is based on UnitedHealthcare Dental's determination of charges for the procedure or procedures.
Network Allowance	Network Allowance means the allowance per procedure that UnitedHealthcare Dental has negotiated with the provider and they have agreed to accept as payment in full for their services.
Plan	UnitedHealthcare Dental
Sponsor	Generally, a sponsor means the individual who is eligible for medical or dental benefits under 10 U.S.C. chapter 55 based on their direct affiliation with the uniformed services (including military members of the National Guard and Reserves).

TEI certifying family member	Under circumstances where a sponsor is not an enrollee, a TEI family member may accept responsibility to self-certify as an enrollee and enroll TEI family members
TRICARE-eligible individual (TEI) family member	TEI family members include a sponsor's spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in a sponsor's legal custody by a court. Children include legally adopted children, stepchildren, and pre- adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.
We/Us	UnitedHealthcare Dental
You	Enrollee or eligible family member.

Non-FEDVIP Benefits

UnitedHealthcare Hearing*

As a UHC Specialty member, you and your family have access to savings on a wide selection of name-brand and private-labeled hearing aids as well as professional care through the UnitedHealthcare Hearing provider network.

*30-50% off MSRP on hundreds of name-brand and private-labeled hearing aids from major manufacturers, including Beltone™, Phonak, ReSound, Signia, Starkey®, Unitron™ and Widex®.

*6500+ credentialed hearing provider locations nationwide that provide hearing tests, hearing aid evaluations and follow-up support.

*Members can purchase state of the art technology programmed for members' unique hearing loss through a UnitedHealthcare Hearing network provider.

*Extended 3-year warranty, one-time loss or damage replacement, trial-period and free batteries or charging case with each hearing aid purchased.

*Professional, nationwide support plus online tutorials, hearing health tips and more to help you stay connected and get the most out of your hearing aids.

To register, please visit www.uhchearing.com or call 1-855-523-9355, Monday through Friday, 8:00 am to 8:00 pm CT. You will also be able to access the hearing aid discount through the Benefit Hub.

Laser Vision Correction*

Discounts on Laser Vision Correction - UnitedHealthcare Dental participants have access to QualSight LASIK. QualSight offers a network of credentialed ophthalmologists with more than 900 locations in 46 states. QualSight LASIK provides FEDVIP members with up to 35% off the national average price of laser vision correction. Visit uhc.qualsight.com or call 1-855-321-2020, Monday through Friday 7:00 am to 7:00 pm CT and Saturday - Sunday, 9:00 am to 3:00 pm CT.

Financial Wellness Options**

UnitedHealthcare family of companies are ready to help you with plans to fit your individual financial picture.

SafeTrip – Travel benefits if an emergency arises while out of the country. As part of your SafeTrip travel protection plan, UnitedHealthcare Global provides you with medical and travel-related assistance services. To enroll visit https://www.uhone.com/health-insurance/supplemental/safetrip-travel-insurance or call 1-800-586-0739.

Accidental Insurance - Program options that offer benefits paid in a lump sum directly to you for eligible expenses related to accidental injury. These benefits are paid regardless of other insurance coverage you have, up to your chosen annual maximum. Visit https://www.uhone.com/health-insurance/supplemental/accident-insurance or call 1-800-273-8115 for details and plan cost and availability in your area.

Term Life - Program offers benefits if your family relies on your income to keep up with their day-to-day living expenses, the financial implications of your death could be devastating for them. Term Life Insurance from UnitedHealthcare, underwritten by Golden Rule Insurance Company, can play a part in helping you to protect your family's finances in your absence. Visit https://www.uhone.com/health-insurance/supplemental/term-life-insurance or call 1-800-273-8115 for details and plan cost and availability in your area.

Critical Illness Insurance - Critical Illness insurance, also known as Critical Care insurance or Critical Illness coverage, pays a lump sum cash benefit directly to the policyholder in the event of a qualifying serious illness. Visit https://www.uhone.com/health-insurance/supplemental/critical-illness-insurance or call 1-800-273-8115 for details and plan cost and availability in your area.

***Programs available at no additional premium cost to you.**

****Programs may involve additional cost.**

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 (1-877-888-3337), TTY number 1-877-889-5680.
- The calendar year deductible is $0 if you use an in-network provider. If you elect to use an out-of-network provider, the Standard Option has deductible amounts of $100 for Self, $200 for Self Plus One, and $300 for Family for Class A, B, and C services; High Option has deductible amounts of $50 for Self, $100 for Self Plus One, and $150 for Family for Class B and C services.
- Included with your plan benefits is comprehensive coverage for various methods of annual oral cancer screenings for all adults. In addition included in your plan is a Supplemental Oral Cancer Benefit. Any UnitedHealthcare Dental member who receives a diagnosis of Oral, Head and Neck Cancer, and who has an impact to their teeth and supporting structures, is eligible for a one-time single lump sum payment of $2,000 to cover expenses such as lost wages, child care, and more. This added financial benefit can be used at the member's discretion as they navigate the various demands this diagnosis may bring. This is a fixed oral cancer benefit to aid with the unexpected dental care and personal disruptions often bringing an added financial burden.
- The Enhanced Member Benefits offer additional services to our UnitedHealthcare Dental members who have been diagnosed and are managing one or more of eight medical conditions listed below. The additional dental services will be covered at 100%, require no referral, and will not count towards the member's deductible or annual maximum.
- UnitedHealthcare Dental members with one or more of the following chronic conditions will be eligible for this benefit: Asthma, Coronary Artery Disease/Cardiovascular Disease, Chronic Obstructive Pulmonary Disease (COPD), Pregnancy, Cerebrovascular Disease, Diabetes, Kidney Disease, Rheumatoid Arthritis.
- Eligible members will be able to sign up for Enhanced Member Benefits using a simple, one-step process available on the UnitedHealthcare Dental member website. Once the clinical exception form is completed, members are eligible to receive the enhanced services as their claims are received. No supplemental claim submission is required
  - Enhanced Service*: Additional prophylaxis (cleaning) per year, traditional or gingival. Allowable Maximum: Up to 4 cleanings annually, using any combination of codes D1110, D4346 and D4910
  - Enhanced Service*: Scaling and root planing; per quadrant. Allowable Maximum: Up to 1 annual treatment per quadrant.
  - Enhanced Service*: Full mouth debridement. Allowable Maximum: One treatment per 24 months.
  - Enhanced Service*: Periodontal maintenance. Allowable Maximum: Up to 4 cleanings annually, using any combination of codes D1110, D4346 and D4910.
  - Enhanced Service*: Localized delivery of antimicrobial agents (not covered for pregnancy). Allowable Maximum: Up to 2 sites treated in one date of service, using code D4381, with a maximum of 24 sites treated per lifetime.

***These services are covered at 100% for eligible members, there is no cost when visiting an in-network dentist. Services do not count toward annual benefit maximums. Annual Deductible does not apply.**

High Option Benefits	You Pay	
	In-Network	Out-of-Network
Class A (Basic) Services – preventive and diagnostic	0%	10%
Class B (Intermediate) Services – includes minor restorative services	30%	40%
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	50%	60%
Class A, B, and C Services do not have an annual maximum benefit amount for in-network services	Unlimited	$3,000
Class D Services – orthodontic up to $2,000 per adult and $4,000 per child lifetime maximum combined for in-network or out-of-network	50%	50%

Standard Option Benefits	You Pay	
	In-Network	Out-of-Network
Class A (Basic) Services – preventive and diagnostic	0%	10%
Class B (Intermediate) Services – includes minor restorative services	45%	60%
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	65%	80%
Class A, B, and C Services are subject to a combined $1,500 annual maximum benefit for the in-network benefits or $1,000 for the out-of-network benefits. The Annual Benefit Maximums within each option are combined between in and out-of-network services. The total Annual Benefit Maximum will never be greater than the in-network Maximum Annual Benefit.	$1,500	$1,000
Class D Services – orthodontic $2,000 lifetime maximum per person combined for in-network or out-of-network	50%	50%

Stop Health Care Fraud!

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, UnitedHealthcare Dental, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your explanation of benefits (EOBs) statements.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-866-315-2321 or TTY 711 and explain the situation, you will be required to state your complaint in writing to us.

Do not maintain as a family member on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
- Your child over age 22 (unless they are disabled and incapable of self- support). With respect to TRICARE-eligible individuals, 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.

If you have any questions about the eligibility of a dependent, please contact BENEFEDS at www.BENEFEDS.gov or 1-877-888-3337, TTY 1-877-889-5680

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

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

Notes

Notes

Notes

Rate Information

How to find your rate

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

Premium Rating Areas by State/Zip Code (first three digits)								
State	**Zip**	**Rating Region**	**State**	**Zip**	**Rating Region**	**State**	**Zip**	**Rating Region**
AK	995-999	5	KY	400-409,411-418,42-0-427	1	NY	140-143	1
AL	350-352,354-369	1	KY	410,459	2	OH	430-433,437,450-452	2
AR	716-729	1	LA	700,701,703-708,71-0-714	1	OH	434-436,438-449,4-53-458	1
AZ	850-853	4	MA	010, 011, 013	4	OK	730,731,734-741,74-3-749	1
AZ	855-857,859,860,86-3,865	2	MA	012,014-027,055	3	OR	970-973	5
AZ	864	3	MD	205-212,214,216,21-7,219	3	OR	974-979	3
CA	900-908,910-928,9-30,931,933-935,939--941,943-952,954	5	MD	215,218	1	PA	150-171,175-179,1-82,184-188	1
CA	932,936-938,953,95-5,960,961	3	ME	039-042	3	PA	172-174,189-196	3
CA	942,956-959	4	ME	043-049	2	PA	180, 181, 183	5
CO	800-806	4	MI	480-485	3	PR	006, 007, 009	1
CO	807,811,813-816	2	MI	486-499	2	RI	028, 029	3
CO	808-810,812	3	MN	550,551,553-555,563	5	SC	290-296,298,299	2
CT	060-063	4	MN	556-562,564-567	2	SC	297	3
CT	064-069	5	MO	630,631,633,640,64-1,000,000,000	2	SD	570-577	1
DC	200,202-205	3	MO	634-639,646-648,6-50-658	1	TN	370-385	1
DE	197-199	3	MS	386-397	1	TX	733,786,787	4
FL	320-329,335-339,3-41,342,344,346,347	1	MT	590-599	1	TX	739,755-759,763-7-69,776-785,788-799,885	1
FL	330-334,349	3	NC	270-279,283-289	2	TX	750-754,760-762,7-70,772-775	3
GA	300-303,305,306,31-1,399	3	NC	280-282	3	UT	840-847	5
GA	304,307-310,312-3-19,398	1	ND	580-588	1	VA	201,203,205,220-22-7,230,232,238	3
GU	969	5	NE	680,681	2	VA	228,229,239-246	1
HI	967-968	3	NE	683-693	1	VA	231,233-237	2
IA	500-514,516,520-528	1	NH	030-033,038	3	VI	008	1
IA	515	2	NH	034-037	4	VT	050-053,056-059	3
ID	832-838	3	NJ	070-079,085-089	5	VT	054	4
IL	600-609,613	3	NJ	080-084	3	WA	980-986,988-994	5
IL	610-612,614-619,6-23-629	1	NM	870,871,873-875,87-7-884	1	WI	530-532,534,535,53-7-539,541-549	3
IL	620,622	2	NV	889-891	3	WI	540	5
IN	460-462,470,472,473	2	NV	893-895,897,898	4	WV	247-253,255-268	1
IN	463-464	3	NY	005,100-119,124-126	5	WV	254	3
IN	465-469,471,474-479	1	NY	063	4	WY	820-831	1
KS	660-662,666	2	NY	120-123,128	3	WY	834	3
KS	664,665,667-679	1	NY	127,129-139,144-149	2	Interna-tional	All	5

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	$20.60	$41.20	$61.80	$44.63	$89.27	$133.90
2	$21.63	$43.26	$64.90	$46.87	$93.73	$140.62
3	$22.71	$45.43	$68.14	$49.21	$98.43	$147.64
4	$26.14	$52.28	$78.42	$56.64	$113.27	$169.91
5	$30.72	$61.43	$92.15	$66.56	$133.10	$199.66

Rating Area	Standard - Bi-Weekly			Standard - Monthly		
	Self Only	Self Plus One	Self and Family	Self Only	Self Plus One	Self and Family
1	$11.42	$22.83	$34.25	$24.74	$49.47	$74.21
2	$12.91	$25.82	$38.73	$27.97	$55.94	$83.92
3	$13.88	$27.76	$41.64	$30.07	$60.15	$90.22
4	$14.60	$29.20	$43.80	$31.63	$63.27	$94.90
5	$16.96	$33.93	$50.89	$36.75	$73.52	$110.26

UnitedHealthcare Vision Plan

https://fedvip.myuhcvision.com

1-866-249-1999 or TTY 711

United Healthcare

2025

A Nationwide PPO Vision 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 29

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 UnitedHealthcare Vision Plan under UnitedHealthcare Vision Plan's (formerly Spectera) contract OPM02-FEDVIP-02AP-16 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

UnitedHealthcare Vision
10175 Little Patuxent Parkway
6th Floor
Columbia, MD 21044
1-866-249-1999, TTY 711
www.fedvip.myuhcvision.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.

UnitedHealthcare Vision Plan is responsible for the selection of in-network providers in your area. Contact us at 1-866-249-1999 or TTY 711 - for the names of participating providers. You may view the most current directory via our web site at www.fedvip.myuhcvision.com. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided, not for 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 may nominate them to join. Nomination forms are available on our web site, or call us and we will have a form sent to you. You cannot change plans outside of open season because of changes to the provider network.

Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If you require the services of a specialist and one is not available in your area, please contact us for assistance.

This UnitedHealthcare 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 at www.fedvip.myuhcvision.com, and then click on the "Legal and Privacy Notices" 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 1-866-249-1999, TTY 711.

Discrimination is Against the Law

UnitedHealthcare 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, UnitedHealthcare 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; 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 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 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.

Changes for 2025

There are no benefit changes to either our High or Standard Option Plans for 2025

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

You may continue your FEDVIP enrollment 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.

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. A 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 does 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 (1-877-888-3337), TTY number 1-877-889-5680 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not want to change plans, your enrollment will continue automatically. Please Note: your plans' premiums may change for 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.

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

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 QLE's and the enrollment actions you may take:

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

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

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

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

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

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

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

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

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

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

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

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

- There is no time limit for a change based on moving from a regional plan's service area; and
- You cannot request a new enrollment based on a QLE before the QLE occurs, except for enrollment because of the 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 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 1-877-888-3337, 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;
- as sponsor or primary enrollee leaves active duty;
- begin a period of non-pay status or pay that is insufficient to have your FEDVIP premiums withheld and you do not make direct premium payments to BENEFEDS;
- are making direct premium payments to BENEFEDS and you stop making the payments;
- cancel the enrollment during open season;
- a Retired Reservist begins active duty; or
- the sponsor or primary enrollee leaves active duty.

Coverage for a family member ends when:

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

Continuation of Coverage

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

- 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.

Identification Cards/ Enrollment Confirmation

Enroll online at www.BENEFEDS.gov Upon confirmation of your enrollment, you will be sent welcome packet with a new member checklist. Your UnitedHealthcare Vision Plan identification card is available electronically at www.myuhc.com if you have a UnitedHealthcare Medical Plan or https://fedvip.myuhcvision.com if you do not have a UnitedHealthcare Medical Plan. You may contact customer service at 1-866-249-1999 or TTY 711 for a physical card to mailed to your home address.

Where You Get Covered Care

You may visit any provider in the UnitedHealthcare Vision network. Log on to https://fedvip.myuhcvision.com and select the provider locator option. You may also contact UnitedHealthcare Vision's 24-hour, toll-free Interactive Voice Response (IVR) system dedicated to Federal employees and annuitants at 1-866-249-1999 or TTY 711. You may elect to visit any vision provider to utilize your benefit, even if they are not part of the UnitedHealthcare Vision provider network.

Plan Providers

We list plan providers on our Web site at https://fedvip.myuhcvision.com. In addition, you can call UnitedHealthcare Vision Plan's 24-hour, toll-free Interactive Voice Response (IVR) system dedicated to Federal employees and annuitants at 1-866-249-1999 or TTY 711.

In-Network

Once you locate an in-network provider, call the provider directly to schedule your appointment. Identify yourself as having UnitedHealthcare Vision coverage and provide the primary insured's subscriber number and patient's name and date of birth. You can find participating providers at https://fedvip.myuhcvision.com.

Out-of-Network

If you choose to use an out-of-network provider, your reimbursement will not exceed the out-of-network maximums listed in this brochure. In order to receive reimbursement, please submit the itemized paid receipt(s), along with the primary insured's subscriber number and patient's name and date of birth to:

UnitedHealthcare Vision
Attention: Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

It is important to note that you must pay the out-of-network provider in full at the time of service, and then submit your receipt(s) to UnitedHealthcare Vision for reimbursement. Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of the date of service.

FEHB/PSHB First Payor

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. The FEDVIP plan allowance will be the prevailing charge, in these cases. You are responsible for the difference between the FEHB/PSHB and FEDVIP benefit payments and the FEDVIP plan allowance. UnitedHealthcare Vision is responsible for facilitating the process with the FEHB/PSHB first payor. You can assist with this process and ensure that you are receiving the maximum allowable benefit under each program by presenting both numbers when submitting the claim to the plans.

The amounts listed in the chart below are for example purposes only and *do not* reflect your FEHB/PSHB or UnitedHealthcare Vision benefits. The example does not include your copay which you are responsible for paying.

Services: Eye Exam $90
FEHB/PSHB Pays: $20
UnitedHealthcare Vision: $70

Services: Frame $130
FEHB/PSHB Pays: $0
UnitedHealthcare Vision: $130

Services: Lenses $60
FEHB/PSHB Pays: $30
UnitedHealthcare Vision: $30

Services: Total $280
FEHB/PSHB Pays: $50
UnitedHealthcare Vision: $230

Your FEHB/PSHB will pay $50.00. Your UnitedHealthcare Vision will then pay up to the Plan allowance not to exceed $230 in this example.

Coordination of Benefits

When you have vision coverage through a non-FEHB/non-PSHB Plan and UnitedHealthcare Vision coverage under FEDVIP, UnitedHealthcare Vision is the primary payor and your non-FEHB/non-PSHB plan is secondary.

We may request that you verify/identify your health insurance plan(s) annually or at time of service.

The amounts listed in chart below are for example purposes only and *do not* reflect your non-FEHB/non-PSHB or UnitedHealthcare Vision benefits. The example does not include your copay which you are responsible for paying.

Services: Eye Exam $90
In-Network UnitedHealthcare Vision Plan: $90 (fully covered)
Non-FEHB/Non-PSHB: $0

Services: Frame $200
In-Network UnitedHealthcare Vision Plan: $130
Non-FEHB/Non-PSHB: $70

Services: Lenses $60
In-Network UnitedHealthcare Vision Plan: $60 (fully covered)
Non-FEHB/Non-PSHB: $0

Services: Total $350
In-Network UnitedHealthcare Vision Plan: $280
Non-FEHB/Non-PSHB: $70

UnitedHealthcare Vision will pay up to the plan allowance not to exceed $280 in this example. Your non-FEHB/non-PSHB Plan will pay $70

Services: Eye Exam $90
Out of Network UnitedHealthcare Vision Plan: $40
Non-FEHB/Non-PSHB: $50

Services: Frame $200
Out of Network UnitedHealthcare Vision Plan: $45
Non-FEHB/Non-PSHB: $0

Services: Lenses $60
Out of Network UnitedHealthcare Vision Plan: $40
Non-FEHB/Non-PSHB: $20

Services: Total $350
Out of Network UnitedHealthcare Vision Plan: $125
Non-FEHB/Non-PSHB: $70

UnitedHealthcare Vision will pay up to the plan allowance not to exceed $125 in this example. Your non-FEHB/non-PSHB Plan will pay $70.

Limited Access Areas	If you live in an area that does not have a UnitedHealthcare Vision provider located within 15 miles of your primary residence for urban ZIP codes, or 35 miles of your primary residence for rural ZIP codes, we will pay 100% of your plan allowance when you receive covered services from an out-of-network provider. Follow the out-of-network claims submission instructions in Section 8, “How to file a claim for covered services.”

Section 4 Your Cost for Covered Services

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

Copayment	A copayment is a fixed amount of money you pay to the provider when you receive services. Example: In our plan, you have no eye exam copay and a copay for eyewear materials (if needed). For materials, Standard Option members have a $25 copay, while High Option members have a $0 materials copay. The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.
Coinsurance	Coinsurance is the percentage of billed charges that you must pay for your care. Coinsurance for your UnitedHealthcare Vision Plan only applies to coverage for low vision and vision therapy, and does not apply to any other portion of the UnitedHealthcare Vision benefit. Example: For either low vision or vision therapy services, you will follow the out-of-network process and pay the provider in full at the time of service. You then submit your receipts to our claims department, and will be reimbursed 75% of the billed charges, up to the lifetime benefit maximum for both vision therapy and low vision services.
Annual Benefit Maximum	For the UnitedHealthcare Vision Plan, you can receive an eye exam, frames, and lenses – or contact lenses in lieu of eyeglasses, once per year and other vision testing as described in Section 5, Vision Services and Supplies.
Lifetime Benefit Maximum	There is a lifetime maximum reimbursement of $1,000 for low vision and $1,000 for vision therapy services. There is also a lifetime maximum reimbursement of $1,500 for a prosthetic eye. There is no lifetime benefit maximum associated with any other portion of the UnitedHealthcare Vision Plan.
In-Network Services	When you receive services from a UnitedHealthcare Vision in-network provider, you are responsible only for the copays, coinsurance levels and amounts that exceed lifetime maximums as shown in Section 5, Vision Services and Supplies.
Out-of-Network Services	When visiting an out-of-network provider, pay the provider in full at the time of service and you will be reimbursed up to the amounts indicated below: Eye Exam: $40 Lens: Single Vision: $40 Lens: Lined bifocal: $60 Lens: Lined trifocal: $80 Lens: Lenticular: $80 Frames: $45 Elective Contact Lenses: $125 Necessary Contact Lenses: $210
Limited Access Areas	When visiting an out-of-network provider, in a limited access area, pay the provider in-full at the time of service and you will be reimbursed up to the amounts indicated below: Eye Exam: $100 Lens: Single Vision: $80 Lens: Lined bifocal: $100 Lens: Lined trifocal: $135 Lens: Lenticular: $150 Frames: $130 Elective Contact Lenses: $150 Necessary Contact Lenses: $210

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

Benefit Description	You Pay	
Diagnostic	**Standard**	**High**
92002-92004 New patient examination 92012-92014 Established patient examination One of either listed above in a calendar year Covered dependent children, under age 19, are eligible for an additional eye exam each plan year for no copay (standard & high options). Children under age 19, whose prescription changes by a .5 diopter or greater will receive an additional pair of glasses in accordance with their Plan's materials copay and benefit design. Pregnant, post-partum, or breastfeeding members are eligible for an additional eye exam each plan year for no copay (standard & high options). Those whose prescription change by a .5 diopter or greater will receive an additional pair of glasses in accordance with their Plan's materials copay and benefit design. Receive a comprehensive eye examination from a state-licensed optometrist or ophthalmologist. An eye exam with refraction is a general evaluation of the complete visual system. This service includes: • Taking a complete medical and visual history • General medical observation • Visual acuities • Pupil evaluation • Ocular motility testing and binocular function tests • Color vision test • Keratometry • Retinoscopy • Refraction • External examination of the eye • Ophthalmoscope examination of the internal eye (includes a routine dilated eye exam) • Gross visual fields (confrontation fields) • Biomicroscopy • Tonometry • Initiation of diagnostic and treatment programs	No copay	No copay

Diagnostic - continued on next page

Benefit Description	You Pay	
Diagnostic (cont.)	**Standard**	**High**
The comprehensive eye exam will evaluate the eye for diseases of the visual system, such as glaucoma, cataracts, macular degeneration, diabetic retinopathy, and hypertensive retinopathy.	No copay	No copay
Eyewear	**Standard**	**High**
Lenses – One pair of standard single vision, lined bifocal, lined trifocal, standard lenticular lenses is covered-in-full. Covered dependent children, under age 19, are eligible for an additional eye exam each plan year for no copay (standard & high options). Children under age 19, whose prescription changes by a .5 diopter or greater will receive an additional pair of glasses in accordance with their Plan's materials copay and benefit design. Pregnant, post-partum, or breastfeeding members are eligible for an additional eye exam each plan year for no copay (standard & high options). Those whose prescription change by a .5 diopter or greater will receive an additional pair of glasses in accordance with their Plan's materials copay and benefit design. V2100 - V2114 Single Vision V2200 - V2214 Bifocal V2300 - V2314 Trifocal V2115 - Lenticular - Single Vision V2215 - Lenticular - Bifocal V2315 - Lenticular - Trifocal	$25 copay	No copay
Frames - *It is important to note that the materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.*	$25 copay	No copay
(one every 12 months as needed) – Receive a frame allowance as indicated by plan V2020 Covered Frame V2025 Non-Covered Frame	Nothing for frames up to the $200 plan allowance	Nothing for frames up to the $225 plan allowance

Eyewear - continued on next page

Benefit Description	You Pay	
Eyewear (cont.)	**Standard**	**High**
Covered Patient Options		
Standard scratch-resistant coating	$0.00	$0.00
Polycarbonate	$0.00	$0.00
Non-glass Standard Photochromic Lenses covered	$0.00	$0.00
Tinted lenses, solid	$0.00	$0.00
UV Coating	$0.00	$0.00
V2781 Tier l Progressive Lenses	$25.00	$0.00
High-end (Tier ll-V) Progressive Lenses	$100.00 - $250.00	$65.00 copay
Tier l Anti-Reflective Coating	$30.00	$0.00
High Index Plastic up to 1.73	$30.00 - $69.00	$30.00 - $69.00
Note: Coverage for some Optical Lens Extras, which may include progressive lenses, may be included with eyeglass packages offered at some Network locations. For additional information, please contact Customer Service at 1-866-249-1999, TTY 711.		
Elective Contact Lenses		
Allowance is applied toward the purchase of contact lenses. *No copay applies.*	All charges over the $125 allowance for contact lenses.	All charges over the $125 allowance for contact lenses
Elective Contact Lenses Fitting & Evaluation	All charges over the $40 fitting/evaluation allowance for in-network	All charges over the $40 fitting/evaluation allowance for in-network
Allowance is applied toward the contact lens fitting/ evaluation fees. *No copay applies.*		
Necessary Contact lenses*:		
* Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. **If your provider considers your contacts necessary, your provider must contact UnitedHealthcare Vision concerning the reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.**	$25 materials copay	$0 materials copay

Other Vision Testing – A reimbursement for services that typically goes beyond what is covered by a routine vision examination. **Plan pays every calendar year:**

92060	Special Eye Evaluation	$85
92065	Orthoptics &/or Pleoptics Evaluation/Training	$60
92071-92072	Fit Contacts for Treatment of Disease	$114
92100	Serial Tonometry Exam(s)	$60
92136	Ophthalmic Biometry by Partial Coherence Interferometry	$220

Low Vision – Reimbursement for low vision services to ensure members are equipped to cope with visual impairment. **The low vision coverage has a lifetime maximum reimbursement of $1,000, in which we would pay 75% of the claim (member responsible for 25% coinsurance).**

99242	Office consultation for a new or established patient. Usually the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99243	Office consultation for a new or established patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient. Usually the presenting problem(s) are of moderate to high severity.
92354	Fitting of spectacle mounted low vision aid; single element system
92355	Fitting of telescopic or other compound system
V2600	Hand held low vision aids and other nonspectacle aids
V2610	Single lens spectacle mounted low vision aids
V2615	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes, and compound microscopic lens system

Vision Therapy – Reimbursement for therapeutic services, **up to a lifetime maximum of $1000 in which we would pay 75% of the claim (member responsible for 25% coinsurance).**

99242	Office consultation for a new or established patient. Usually the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99243	Office consultation for a new or established patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient. Usually the presenting problem(s) are of moderate to high severity.
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation.

Prosthetic Eye – Claims are submitted following the out-of-network procedure and there is a **one-time reimbursement for the cost of a prosthetic eye, up to $1,500.**

V2632	Prosthetic eye
V2623	Prosthetic eye plastic custom
V2629	Prosthetic eye other type

Section 6 International Services and Supplies

If you live outside of the United States and its territories, 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.

International Claims Payment	When visiting an international provider, you will pay the provider in-full at the time of service, and you will be reimbursed up to the amounts shown below. Reimbursement will be converted from foreign currency into U.S. dollars. Eye Exam: $80 Lens: Single Vision: $60 Lens: Lined bifocal: $80 Lens: Lined trifocal: $115 Lens: Lenticular: $130 Frames: $110 Elective Contact Lenses: $130 Necessary Contact Lenses: $200
Finding an International Provider	You may choose any vision care provider.
Filing International Claims	Submit the itemized paid receipt(s), along with the primary insured's unique identification number and patient's name and date of birth, to: UnitedHealthcare Vision Attention: Claims Department P.O. Box 30978 Salt Lake City, UT 84130 Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of the date of service.
Customer Service Website and Phone Numbers	Contact us at 1-866-249-1999 or TTY 711. You can also go to our Web site at https://fedvip.myuhcvision.com

Section 7 General Exclusions – Things We Do Not Cover

The exclusions in this section apply to all benefits. We do not cover the following:

- Any vision service or treatment not specifically listed as a covered service;
- Services and treatments that are experimental or investigational;
- Services and treatments which are for any illness or bodily injury which occurs in the course of employment if benefits or compensation is available, in whole or in part, under the provision of any legislation of any governmental unit. This exclusion applies whether or not you claim the benefits or compensation;
- Services and treatments for which the cost is later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law;
- Services and treatments incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatments not meeting accepted standards of vision practice;
- Services and treatments resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services or treatments provided as a result of intentionally self-inflicted injury or illness;
- Services or treatments provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- State or territorial taxes on vision services performed.

The following services and materials are excluded from coverage under the policy:

- Post cataract lenses;
- Non-prescription items;
- Medical or surgical treatment for eye disease that requires the services of a physician;
- Workers' Compensation services or materials;
- Services or materials that the patient, without cost, obtains from any governmental organization or program;
- Services or materials that are not specifically covered by the policy;
- Replacement or repair of lenses and/or frames that have been lost or broken;
- Cosmetic extras, except as stated in the policy's table of benefits.

This plan is designed to cover your vision needs rather than cosmetic materials. If you select any of the following, you will be responsible for an additional charge: Cosmetic lenses.

The following professional services or materials are not covered:

- Plano lenses (non-prescription)
- Two pairs of glasses, in lieu of bifocals

- Lenses and frames furnished under this program that are lost or broken will not be replaced except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes, except where specifically shown as a covered expense;
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
- Corrective vision services, treatments, and materials of an experimental nature.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

You do not need to file a claim when you visit a network provider. However, if you visit an out-of-network provider submit the itemized paid receipt(s), along with the primary insured's unique identification number and the patient's name and date of birth to:

UnitedHealthcare Vision
Attention: Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of the date of service.

Deadline for Filing Your Claim

Receipts for out-of-network service must be submitted within 12 months of the date of service.

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:

Submit your appeal in writing to:

UnitedHealthcare Vision Claims Department
Attention: Claims Appeals
P.O. Box 30978
Salt Lake City, UT 84130

Appeal requests must be in writing and received by UnitedHealthcare Vision within 180 days after your receipt of the Notice of Benefit Determination. Should you not receive the Notice of Benefit Determination within 30 days of submission of the original claim, you may submit your appeal within 180 days after this 30-day period has expired.

2. We have 30 days from the date we received your request to decide on your appeal. If an appeal is denied, a written Notice of Benefit Appeal Determination will be sent to you.

3. If the dispute is not resolved through the reconsideration process, you may request a review of the denial. You must submit your request for a reconsideration denial review in writing to:

UnitedHealthcare Vision
Attn: Reconsideration Review
P.O. Box 30978
Salt Lake City, UT 84130

Reconsideration review requests must be in writing and received by UnitedHealthcare Vision within 60 days after your receipt of the Notice of Benefit Appeal Determination. We have 30 days from the date we received your request to decide on the reconsideration.

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 and is the final review of your claim.

5. You cannot bring judicial action prior to exhausting the administrative review process outlined above. You cannot sue OPM, the independent third party reviewer or any other entity. If you prevail in court, you can only recover the amount of benefits in dispute.

Section 9 Definitions of Terms We Use in This Brochure

Annual Benefit Maximum	The maximum annual benefit that you can receive per person.
Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Calendar Year	January 1 to December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends December 31 of the same year.
Enrollee	The Federal employee, annuitant, or TRICARE-eligible individual enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Low vision	Visual impairment where the person retains some usable vision.
Orthoptics	An ophthalmic field pertaining to the evaluation and treatment of patients with disorders of the visual system with an emphasis on binocular vision and eye movements.
Plan Allowance	The amount we use to determine our payment for certain vision care services, such as the frame allowance and contact lens allowance, as well as for out-of-network services.
Pleoptics	The study and treatment of defects in binocular vision resulting from defects in the optic musculature or of faulty visual habits. It involves a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision.
Sponsor	Generally, a sponsor means the individual who is eligible for medical or dental benefits under 10 U.S.C. chapter 55 based on their direct affiliation with the uniformed services (including military members of the National Guard and Reserves).
TEI certifying family member	Under circumstances where a sponsor is not an enrollee, a TEI family member may accept responsibility to self-certify as an enrollee and enroll TEI family members
TRICARE-eligible individual (TEI) family member	TEI family members include a sponsor's spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in a sponsor's legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.
Vision Therapy	Therapeutic services used to treat common vision problems.
We/Us	UnitedHealthcare Vision
You	Enrollee or eligible family member.

Non-FEDVIP Benefits

UnitedHealthcare Hearing*

As a UHC Specialty member, you and your family have access to savings on a wide selection of name-brand and private-labeled hearing aids as well as professional care through the UnitedHealthcare Hearing provider network.

*30-50% off MSRP on hundreds of name-brand and private-labeled hearing aids from major manufacturers, including Beltone™, Phonak, ReSound, Signia, Starkey®, Unitron™ and Widex®.

*6500+ credentialed hearing provider locations nationwide that provide hearing tests, hearing aid evaluations and follow-up support.

*Members can purchase state of the art technology programmed for members' unique hearing loss through a UnitedHealthcare Hearing network provider.

*Extended 3-year warranty, one-time loss or damage replacement, trial-period and free batteries or charging case with each hearing aid purchased.

*Professional, nationwide support plus online tutorials, hearing health tips and more to help you stay connected and get the most out of your hearing aids.

To register, please visit www.uhchearing.com or call 1-855-523-9355, Monday through Friday, 8:00 am to 8:00 pm CT. You will also be able to access the hearing aid discount through the Benefit Hub.

Laser Vision Correction*

Discounts on Laser Vision Correction - UnitedHealthcare Vision participants have access to QualSight LASIK. QualSight offers a network of credentialed ophthalmologists with more than 900 locations in 46 states. QualSight LASIK provides FEDVIP members with up to 35% off the national average price of laser vision correction. Visit https://uhc.qualsight.com or call 1-855-321-2020, Monday through Friday 7:00 am to 7:00 pm CT and Saturday - Sunday, 9:00 am to 3:00 pm CT.

Experience ExpressExam*

With your UnitedHealthcare FEDVIP Vision plan, you'll get access to ExpressExam, an online prescription renewal service, provided at no additional cost. There is no appointment necessary and it does not replace or impact the exam benefit included in your plan.

Financial Wellness Options**

UnitedHealthcare family of companies are ready to help you with plans to fit your individual financial picture.

SafeTrip – Travel benefits if an emergency arises while out of the country. As part of your SafeTrip travel protection plan, UnitedHealthcare Global provides you with medical and travel-related assistance services.

To enroll visit https://www.uhone.com/health-insurance/supplemental/safetrip-travel-insurance or call 1-800-586-0739.

Accidental Insurance - Program options that offer benefits paid in a lump sum directly to you for eligible expenses related to accidental injury. These benefits are paid regardless of other insurance coverage you have, up to your chosen annual maximum. Visit https://www.uhone.com/health-insurance/supplemental/accident-insurance or call 1-800-273-8115 for details and plan cost and availability in your area.

Term Life - Program offers benefits if your family relies on your income to keep up with their day-to-day living expenses, the financial implications of your death could be devastating for them. Term Life Insurance from UnitedHealthcare, underwritten by Golden Rule Insurance Company, can play a part in helping you to protect your family's finances in your absence. Visit https://www.uhone.com/health-insurance/supplemental/term-life-insurance or call 1-800-273-8115 for details and plan cost and availability in your area.

Critical Illness Insurance - Critical Illness insurance, also known as Critical Care insurance or Critical Illness coverage, pays a lump sum cash benefit directly to the policyholder in the event of a qualifying serious illness.

Visit https://www.uhone.com/health-insurance/supplemental/critical-illness-insurance or call 1-800-273-8115 for details and plan cost and availability in your area.

***Programs available at no additional premium cost to you.**

****Programs may involve additional cost.**

Stop Health Care Fraud!

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

Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, plan, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your explanation of benefits (EOB) statements.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-866-249-1999 or TTY 711 and explain the situation.
- 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).

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.

- **Do not rely on this chart alone.** This page summarizes specific expenses we cover. For more detail, please review the individual sections of this brochure.
- If you want to enroll, or change your enrollment in this plan, please visit www.BENEFEDS.gov or call 1-877-888-FEDS (1-877-888-3337), TTY 1-877-889-5680.

Frequency:

Exam every year. Lenses every year. Frames every year.

Covered dependent children, under age 19, are eligible for an additional eye exam each year for no copay (standard & high options). Children under age 19 whose prescription changes by a .5 diopter or greater will receive an additional pair of glasses in accordance with their Plan's materials copay and benefit design.

Pregnant, post-partum, or breastfeeding members are eligible for an additional eye exam each year for no copay (standard & high options). Those whose prescription change by a .5 diopter or greater will receive an additional pair of glasses in accordance with their Plan's materials copay and benefit design.

Contacts (in lieu of glasses) every year.

Benefits/Services In-Network :
Eye Examination (includes dilation)
High Option You Pay: No Copay
Standard Option You Pay: No Copay

Lenses plus Frames (up to $200 Standard & $225 High Option Retail Frame Allowance): Single Vision Lenses, Bifocal Lenses, Trifocal Lenses, Lenticular lenses:
High Option You Pay: $0 Materials Copay
Standard Option You Pay: $25 Materials Copay

V2781 Tier l Progressive Lenses:
High Option You Pay: $0
Standard Option You Pay: $25

High End (Tier ll-V) Progressive Lenses:
High Option You Pay: $65
Standard Option You Pay: $100-$250

Non-glass Standard Photochromatic lenses:
High Option You Pay: Nothing – covered at 100%
Standard Option You Pay: Nothing – covered at 100%

Standard Scratch Resistant Coating:
High Option You Pay: Nothing – covered at 100%
Standard Option You Pay: Nothing – covered at 100%

Polycarbonate Lenses:
High Option You Pay: Nothing – covered at 100%
Standard Option You Pay: Nothing – covered at 100%

Tier l Anti-Reflective Coating:
High Option You Pay: Nothing – covered at 100%
Standard Option You Pay: $30

Tinted Lenses - Solid:
High Option You Pay: Nothing – covered at 100%
Standard Option You Pay: Nothing – covered at 100%

UV Coating:
High Option You Pay: Nothing – covered at 100%
Standard Option You Pay: Nothing – covered at 100%

High-Index Plastic up to 1.73:
High Option You Pay: $30-$69
Standard Option You Pay: $30-$69

Elective Contact Lenses (up to $125 Allowance):
High Option You Pay: No Copay
Standard Option You Pay: No Copay

Contact Lens Fitting/Evaluation (up to $40 Allowance):
High Option You Pay: No Copay
Standard Option You Pay: No Copay

Necessary Contact Lenses:
High Option You Pay: $0 Copay
Standard Option You Pay: $25 Copay

Many additional lens enhancements are offered with a discount of 20% or more off of retail prices.
Lasik Discount Program – see Non-FEDVIP Benefits section.
For Out-of-Network services and Limited Access Area reimbursements - see Section 4.
For International Services and Supplies reimbursements - see Section 6.

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Rate Information

These rates apply nationwide and internationally.

High - Bi-Weekly			High - Monthly		
Self Only	**Self Plus One**	**Self and Family**	**Self Only**	**Self Plus One**	**Self and Family**
$5.63	**$11.25**	**$16.88**	**$12.20**	**$24.38**	**$36.57**

Standard - Bi-Weekly			Standard - Monthly		
Self Only	**Self Plus One**	**Self and Family**	**Self Only**	**Self Plus One**	**Self and Family**
$3.63	**$7.26**	**$10.89**	**$7.87**	**$15.73**	**$23.60**