Aetna Dental

www.aetnafeds.com

1-800-554-2042

aetna®

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
- Changes for 2025: Page 4
- Summary of Benefits: Page 43

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 6 enrollment regions, including overseas; 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 Aetna Dental under Aetna Life Insurance Company's contract OPM02-FEDVIP-02AP-01 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

Aetna Dental
Federal Plans
PO Box 818047
Cleveland, OH 44181-8047
1-800-537-9384
www.aetnafeds.com

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your benefits. You and your family members do not have a right to benefits that were available before January 1, 2025, unless those benefits are also shown in this brochure.

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated 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.

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

Aetna is responsible for the selection of doctors in their network. Visit www.aetnafeds.com or contact us at 1-800-537-9384 for a list participating doctors. Continued participation of any specific doctor cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not on a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in-network. You cannot change plans 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.

Aetna and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program/Postal Service Health Benefits (PSHB) Program.

We want you to know that protecting the confidentiality of your individually identifiable health information is of the utmost importance to us. To review full details about our privacy practices, our legal duties, and your rights, please visit our website, www.aetnafeds.com then click on the "Privacy Information" 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 1-800-537-9384.

Discrimination is Against the Law

Aetna 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, Aetna 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 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 can 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.

How We Have Changed For 2025

Changes to the High and Standard Option include:

- The following dental codes have been added for the 2025 Plan Year:
  - 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 C)*
  - D7252 Partial extraction for immediate implant placement *(Class C)*
  - D8091 Comprehensive orthodontic treatment with orthognathic surgery *(Class D)*
  - D8671 Periodic orthodontic treatment visit associated with orthognathic surgery *(Class D)*

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, 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.

Survivor Annuitants

If you are a survivor of a deceased Federal/U.S. Postal Service employee or annuitant and you are receiving an annuity, you may enroll or continue the existing enrollment.

Compensationers

A compensationer is someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation Programs (OWCP) due to an on-the-job injury/ illness who is determined by the Secretary of Labor to be unable to return to duty. You are eligible to enroll in FEDVIP or continue FEDVIP enrollment into compensation status.

TRICARE-eligible individual

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

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

Family Members

Except with respect to TRICARE-eligible individuals, family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support. FEDVIP rules, and FEHB/PSHB rules for family member eligibility are **NOT** the same. For more information on family member eligibility visit the website at www.opm.gov/healthcare-insurance/dental-vision/ or contact your employing agency or retirement system.

With respect to TRICARE-eligible individuals, family members include your spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in your legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.

Not Eligible

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

- Deferred annuitants
- Former spouses of employees or annuitants. **Note:** Former spouses of TRICARE-eligible individuals may enroll in a FEDVIP vision plan.
- FEHB/PSHB Temporary Continuation of Coverage (TCC) enrollee
- 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

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 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 (enrollee deployment), Yes (spouse deployment)
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 first time enrollment or 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 family member becomes eligible for VA dental or vision benefits, then you 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 60 days of notification to support the FEDVIP enrollment change or cancellation.

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 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.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-866-353-8058. **Note: FSAFEDS is not open to retired employees or to TRICARE eligible individuals.**

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you 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	ID cards are not provided, and are not required to obtain service. We will send you an enrollment confirmation letter when you enroll. For members who wish to carry an ID card, you may print a copy online from our Aetna Member website. It is important to tell your provider about your FEHB/PSHB coverage at every appointment since most FEHB/PSHB plans offer some level of dental benefits separate from your FEDVIP coverage. This ensures that you receive the maximum allowable benefit under each Program.
Where You Get Covered Care	You may obtain care from any licensed dentist in the United States or overseas.
Plan Providers	We list plan providers in the provider directory, which we update periodically. The list is also on our website which is updated three times per week at: www.aetnafeds.com.
In-Network	We negotiate rates with dentists and other health care providers to help save you money. We refer to these providers as "In-Network providers". These negotiated rates are our Plan allowance for network providers. If you use in-network dentists to obtain covered care, benefits are paid at the in-network level. You are responsible for covered charges up to our negotiated plan allowance. You are not responsible for the difference between the plan payment and the amount billed.
Out-of-Network	You may obtain care from any licensed dentist. If the dentist you use is not part of our network, benefits will be considered out-of-network. Because these providers are out of our network, we pay for out-of-network services based on an out-of-network Plan allowance. You are responsible for the difference between the Plan payment and the amount billed.
Pre-Certification	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.
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. We are responsible for facilitating the process with the primary FEHB/ PSHB payor. **SPECIAL NOTE:** If you are enrolled in Aetna's Consumer Driven Health Plan (CDHP) under the FEHB/PSHB, the Dental Fund will not follow the FEHB/PSHB First Payor rule for any service provided by a network dentist. However, preventive services provided by a non-network dentist would be payable from the Dental Fund and follow the FEHB/PSHB First Payor rule.
Coordination of Benefits	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. **SPECIAL NOTE:** If you are enrolled in Aetna's Consumer Driven Health Plan (CDHP) under the FEHB/PSHB the Dental Fund will not follow the FEHB/PSHB First Payor rule for any service provided by a network dentist. However, preventive services provided by a non-network dentist would be payable from the Dental Fund and follow the FEHB/ PSHB First Payor rule. We may request that you verify/identify your health insurance plan(s) annually or at time of service.

Here is an example of how we would coordinate benefits if a non-FEHB/non-PSHB plan was primary:

Primary plan payment based on schedule fee, we are secondary.
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 may change because of the move.

Limited Access Areas

If you live in an area with limited access to a network provider and you receive covered services from an out-of-network provider, we will pay the same benefit level as if you utilized the services of an in-network provider. You are responsible for any difference between the amount billed and our payment. Call us at 1-800-537-9384, if you are having problems locating a dentist in your area.

Alternate Benefit

If more than one service or procedure can be used to treat the covered person's dental condition, Aetna may decide to authorize coverage only for the less costly covered service or procedure when that service is deemed by the dental profession to be an appropriate method of treatment and the service selected must meet broadly accepted national standards of dental practice. If you and your dentist choose the more expensive treatment, you are responsible for the additional charges beyond the allowance for the alternate service, even if services are provided by an in-network provider.

Dental Review

Our review process includes periodontal surgery, crowns, occlusal adjustments and there are other services that are looked at, if they are submitted on the same claim as another service. Your provider should submit images with crowns and periodontal charting with periodontal surgeries.

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. For Standard option, the family deductible limit is 2x the self only deductible ($100 for in-network and $200 for out-of-network). Note: Eligible dental services applied to the out-of-network deductible will be applied to satisfy the in-network deductible. Eligible dental services applied to the in-network deductible will be applied to satisfy the out-of-network provider deductible.

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

Class B
In-Network High Option: $0
In-Network Standard Option: $50
Out-of-Network High Option: $0
Out-of-Network Standard Option: $100

Class C
In-Network High Option: $0
In-Network Standard Option: $50
Out-of-Network High Option: $0
Out-of-Network Standard Option: $100

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

Coinsurance

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

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

Class B
In-Network High Option: 30%
In-Network Standard Option: 45%
Out-of-Network High Option: 40%
Out-of-Network Standard Option: 70%

Class C
In-Network High Option: 60%
In-Network Standard Option: 65%
Out-of-Network High Option: 60%
Out-of-Network Standard Option: 70%

	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. Note: In-Network and Out-of-Network amounts cross apply. For example on high option, once the $2,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement.
	Maximum Annual Benefits In-Network High Option: Unlimited In-Network Standard Option: $1,500 Out-of-Network High Option: $2,000 Out-of-Network Standard Option: $1,000
Lifetime Benefit Maximum	The Lifetime Maximum is applicable to Orthodontia benefits only. There are no other lifetime maximums under this Plan.
	Lifetime Orthodontic Maximum In-Network High Option: up to $2,000 In-Network Standard Option: up to $2,000 Out-of-Network High Option: up to $2,000 Out-of-Network Standard Option: up to $2,000
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 out-of-network. Because these providers are not part of our network, we pay for out-of-network services based on an out-of-network Plan allowance. Please see Plan allowance below to review how we determine Plan allowance for out-of-network services.
Emergency Services	Emergency services are defined as those dental services needed to relieve pain or prevent the worsening of a condition when that would be caused by a delay.
Plan Allowance	Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Network provider plans determine their allowance in different ways. We determine our allowance as follows: **High option:** • Network Providers – we negotiate rates with doctors, dentists and other health care providers to help save you money. We refer to these providers as "network providers". These negotiated rates are our Plan allowance for network providers. We calculate a member's coinsurance using these negotiated rates. The member is not responsible for amounts billed by network providers that are more than our Plan allowance.

- Non-Network providers – Providers that do not participate in our networks are considered non-network providers. Because they are out of our network, we pay for out-of-network services based on the out-of-network Plan allowance. To figure out the out-of-network Plan allowance, we get information from FAIR Health. Health plans send FAIR Health claims data for services they receive from providers. FAIR Health combines this information into databases that show how much providers charge for services by zip code. Providers' charges for specific procedures are grouped in percentiles from low to high. We use the 80th percentile as the Plan allowance to calculate how much to pay for out of network services. The 80th percentile means 80 percent of charges in the database are the same or less for that service in a particular area. We use the Plan allowance when calculating a member's coinsurance amount. The member is responsible for any amounts billed by the non-network provider that are above the Plan allowance, plus their coinsurance amount.

Standard option:

- Network Providers – we negotiate rates with doctors, dentists and other health care providers to help save you money. We refer to these providers as "Network providers". These negotiated rates are our Plan allowance for network providers. We calculate a member's coinsurance using these negotiated rates. The member is not responsible for amounts billed by network providers that are greater than our Plan allowance.
- Non-Network providers – Providers that do not participate in our networks are considered non-network providers. Our Plan allowance for out-of-network services is based on the in-network negotiated fee for the area. While network providers accept the negotiated fee, members may be billed by out-of-network providers for the difference between the Plan allowance and the provider's fee.

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.
- Alternate benefits - if more than one service can be used to treat your dental conditions, we may decide to authorize alternate treatment coverage only for less costly covered service provided that the service selected must be deemed by the dental profession to be an appropriate method of treatment. If you and your dentist choose the more expensive treatment, you are responsible for the additional charges beyond the allowance for the alternate service, even if services are provided by an in-network provider.
- Any dental service or treatment not listed as a covered service is not eligible for benefits.

High Option - You Pay:

- There is no deductible.
- The annual benefit maximum is unlimited In-Network or $2,000 Out-of-Network per covered person for Class A, B and C services. Note: In-Network and Out-of-Network amounts cross apply. Once the $2,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement.
- **In-Network:** $0. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 10% of our plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Standard Option - You Pay:

- There is no deductible for Class A services.
- The annual benefit maximum is $1,500 In-Network or $1,000 Out-of-Network per covered person for Class A, B and C services. Note: In-Network and Out-of-Network amounts cross apply. Once the $1,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement up to the $1,500 maximum.
- **In-Network:** $0. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 40% of our plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Diagnostic and Treatment Services

D0120 Periodic oral evaluation - established patient – *Limited to two per calendar year – see benefit limitations at the end of this section*

D0140 Limited oral evaluation – problem focused – *Limited to two per calendar year – see benefit limitations*

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

D0150 Comprehensive oral evaluation - new or established patient – *Limited to two per calendar year – see benefit limitations*

D0160 Detailed and extensive oral evaluation - problem focused, by report – *Limited to two per calendar year – see benefit limitations*

D0180 Comprehensive periodontal evaluation - new or established patient – *Limited to two per calendar year*

D0210 Intraoral – comprehensive series of radiographic images – *Limited to one set every 36 months. (Full Mouth series or panoramic images)*

Diagnostic and Treatment Services - continued on next page

Diagnostic and Treatment Services (cont.)
D0220 Intraoral - periapical first radiographic image
D0230 Intraoral - periapical each additional radiographic image
D0240 Intraoral - occlusal radiographic image
D0250 Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector
D0251 Extra-oral posterior dental radiographic image
D0270 Bitewing - single radiographic image – *Limited to one set per calendar year*
D0272 Bitewings - two radiographic images – *Limited to one set per calendar year*
D0273 Bitewings - three radiographic images – *Limited to one set per calendar year*
D0274 Bitewings - four radiographic images – *Limited to one set per calendar year*
D0277 Vertical bitewings - 7 to 8 radiographic images – *Limited to one set every 36 months.*
D0330 Panoramic radiographic image – *Limited to one set every 36 months. (Full Mouth series or panoramic images)*
D0372 Intraoral tomosynthesis - comprehensive series of radiographic images
D0373 Intraoral tomosynthesis – bitewing radiographic image
D0374 Intraoral tomosynthesis - periapical radiographic image
D0387 Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only
D0388 Intraoral tomosynthesis – bitewing radiographic image – image capture only
D0389 Intraoral tomosynthesis – periapical radiographic image – image capture only
D0425 Caries susceptibility tests
D0600 Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum
D0701 Panoramic radiographic image – image capture only - *Limited to one set every 36 months. (Full Mouth series or panoramic images)*
D0705 Extra-oral posterior dental radiographic image – image capture only
D0706 Intraoral – occlusal radiographic image – image capture only
D0707 Intraoral – periapical radiographic image – image capture only
D0708 Intraoral – bitewing radiographic image – image capture only - *Limited to one set per calendar year*
D0709 Intraoral - comprehensive series of radiographic images - image capture only
Preventive Services
D1110 Prophylaxis – adult – *Limited to twice per calendar year*
D1120 Prophylaxis – child – *Limited to twice per calendar year*
D1206 Topical application of fluoride varnish - *Limited to twice per calendar year*
D1208 Topical application of fluoride – excluding varnish - *Limited to twice per calendar year*
D1351 Sealant – per tooth – *Limited to children under age 19. One sealant per tooth in a 3-year period*
D1352 Preventive resin restoration in a moderate to high caries risk patient – permanent tooth - *Limited to children under age 19*
D1353 Sealant repair - per tooth - *Limited to children under age 19*
D1354 Application of caries arresting medicament – per tooth - *Limited to children under age 19*
D1355 Caries preventive medicament application – per tooth - *Limited to children under age 19*
D1510 Space maintainer - fixed, unilateral – per quadrant - *Limited to children under age 19*
D1516 Space maintainer – fixed – bilateral, maxillary
D1517 Space maintainer – fixed – bilateral, mandibular
D1520 Space maintainer - removable, unilateral - per quadrant - *Limited to children under age 19*
D1526 Space maintainer – removable – bilateral, maxillary
D1527 Space maintainer – removable – bilateral, mandibular
D1551 Re-cement or re-bond bilateral space maintainer – maxillary

Preventive Services - continued on next page

Preventive Services (cont.)
D1552 Re-cement or re-bond bilateral space maintainer – mandibular
D1553 Re-cement or re-bond unilateral space maintainer – per quadrant
D1556 Removal of fixed unilateral space maintainer – per quadrant
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 children under age 19*
D2990 Resin infiltration of incipient smooth surface lesions
D2991 Application of hydroxyapatite regeneration medicament – per tooth
D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
Additional Procedures covered as Basic Services
D9110 Palliative treatment of dental pain – per visit
D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician
D9311 Consultation with a medical health care professional
D9440 Office visit - after regularly scheduled hours

Benefit limitations:

- *D0120 Periodic oral evaluation - established patient, D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver, and D0150 Comprehensive oral evaluation - new or established patient* are limited to 2 exams in total, per calendar year.
- *D0140 Limited oral evaluation - problem focused, D0160 Detailed and extensive oral evaluation - problem focused, by report, and D0180 Comprehensive periodontal evaluation - new or established patient* are limited to 2 exams in total, per calendar year.

Not covered:

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

Class B Intermediate

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.
- Alternate benefits - if more than one service can be used to treat your dental conditions, we may decide to authorize alternate treatment coverage only for less costly covered service provided that the service selected must be deemed by the dental profession to be an appropriate method of treatment. If you and your dentist choose the more expensive treatment, you are responsible for the additional charges beyond the allowance for the alternate service, even if services are provided by an in-network provider.
- In-progress treatment for dependents of retiring TDP enrollees will be covered for the 2025 plan year. This is regardless of any current plan exclusions for care initiated prior to the enrollee's effective date.

High Option - You Pay:

- There is no deductible.
- The annual benefit maximum is unlimited In-Network or $2,000 Out-of-Network per covered person for Class A, B and C services. Note: In-Network and Out-of-Network amounts cross apply. Once the $2,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement.
- **In-Network:** 30% of our network allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 40% of the plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Standard Option - You Pay:

- **In-Network calendar year deductible:** $50 Self Only, $100 Self Plus One and $100 Self and Family. All individuals within Self Plus One and Self and Family plans will not pay more than a $50 deductible until the $100 family deductible is satisfied.
- **Out-of-Network calendar year deductible:** $100 Self Only, $200 Self Plus One and $200 Self and Family. All individuals within Self Plus One and Self and Family plans will not pay more than a $100 deductible until the $200 family deductible is satisfied.
- The deductible applies to both Intermediate (class B) and Major services (class C). Note: In-Network and Out-of-Network amounts cross apply.
- The annual benefit maximum is $1,500 In-Network or $1,000 Out-of-Network per covered person for Class A, B and C services. Note: In-Network and Out-of-Network amounts cross apply. Once the $1,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement up to the $1,500 maximum.
- **In-Network:** 45% of our plan allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 70% of our plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Diagnostic and Treatment Services
D0391 Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report
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 - *An alternate benefit of an amalgam will be provided on posterior teeth*
D2392 Resin-based composite - two surfaces, posterior - *An alternate benefit of an amalgam will be provided on posterior teeth*
D2393 Resin-based composite - three surfaces, posterior - *An alternate benefit of an amalgam will be provided on posterior teeth*
D2394 Resin-based composite - four or more surfaces, posterior - *An alternate benefit of an amalgam will be provided on posterior teeth*
D2610 Inlay - porcelain/ceramic - one surface
D2620 Inlay - porcelain/ceramic - two surfaces
D2630 Inlay - porcelain/ceramic - three or more surfaces
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration - *Limited to once per 6 month period per tooth*
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core
D2920 Re-cement or re-bond crown - *Limited to once per 6 month period per tooth*
D2921 Reattachment of tooth fragment, incisal edge or cusp
D2930 Prefabricated stainless steel crown - primary tooth - *Limited to one per patient, per tooth, per lifetime*
D2931 Prefabricated stainless steel crown - permanent tooth - *Limited to one per patient, per tooth, per lifetime*
D2951 Pin retention - per tooth, in addition to restoration
D2989 Excavation of a tooth resulting in the determination of non-restorability

Not Covered:

- *Restorations, including veneers, which are placed for cosmetic purposes only*
- *Gold foil restorations*
- *Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correction attrition, abrasion, or erosion.*

Endodontic Services
D3110 Pulp cap - direct (excluding final restoration)
D3120 Pulp cap – indirect (excluding final restoration)
D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament
D3221 Pulpal debridement, primary and permanent teeth
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)

Endodontic Services - continued on next page

Endodontic Services (cont.)
D3355 Pulpal regeneration - initial visit
D3356 Pulpal regeneration - interim medication replacement
D3357 Pulpal regeneration - completion of treatment
Periodontal Services
D4341 Periodontal scaling and root planing - four or more teeth per quadrant – *Limited to once per quadrant every 24 months*
D4342 Periodontal scaling and root planing - one to three teeth per quadrant – *Limited to once per site every 24 months*
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910 Periodontal maintenance – *Limited to twice per calendar year*
Prosthodontic Services
D5410 Adjust complete denture - maxillary
D5411 Adjust complete denture - mandibular
D5421 Adjust partial denture - maxillary
D5422 Adjust partial denture - mandibular
D5511 Repair broken complete denture base, mandibular
D5512 Repair broken complete denture base, maxillary
D5520 Replace missing or broken teeth – complete denture – per tooth
D5611 Repair resin partial denture base, mandibular
D5612 Repair resin partial denture base, maxillary
D5621 Repair cast partial framework, mandibular
D5622 Repair cast partial framework, maxillary
D5630 Repair or replace broken retentive clasping materials – per tooth
D5640 Replace missing or broken teeth – partial denture – per tooth
D5650 Add tooth to existing partial denture – per tooth
D5660 Add clasp to existing partial denture - per tooth
D5670 Replace all teeth and acrylic on cast metal framework (maxillary)
D5671 Replace all teeth and acrylic on cast metal framework (mandibular)
D5710 Rebase complete maxillary denture – *Not covered within first six months of placement, limited to once in a 36-month period*
D5711 Rebase complete mandibular denture - *Not covered within first six months of placement, limited to once in a 36-month period*
D5720 Rebase maxillary partial denture – *Not covered within first six months of placement, limited to once in a 36-month period*
D5721 Rebase mandibular partial denture – *Not covered within first six months of placement, limited to once in a 36-month period*
D5725 Rebase hybrid prosthesis
D5730 Reline complete maxillary denture (direct) – *Not covered within first six months of placement, limited to once in a 36-month period*
D5731 Reline complete mandibular denture (direct) – *Not covered within first six months of placement, limited to once in a 36-month period*
D5740 Reline maxillary partial denture (direct) – *Not covered within first six months of placement, limited to once in a 36-month period*
D5741 Reline mandibular partial denture (direct) – *Not covered within first six months of placement, limited to once in a 36-month period*
D5750 Reline complete maxillary denture (indirect) – *Not covered within first six months of placement, limited to once in a 36-month period*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D5751 Reline complete mandibular denture (indirect) – *Not covered within first six months of placement, limited to once in a 36-month period*
D5760 Reline maxillary partial denture (indirect) – *Not covered within first six months of placement, limited to once in a 36-month period*
D5761 Reline mandibular partial denture (indirect) – *Not covered within first six months of placement, limited to once in a 36-month period*
D5765 Soft liner for complete or partial removable denture – indirect
D5850 Tissue conditioning, maxillary
D5851 Tissue conditioning, mandibular
D5876 Add metal substructure to acrylic full denture (per arch)
D6092 Re-cement or re-bond implant/abutment supported crown
D6093 Re-cement or re-bond implant/abutment supported fixed partial denture
D6197 Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant
D6930 Re-cement or re-bond fixed partial denture
D6980 Fixed partial denture repair necessitated by restorative material failure
D7921 Collection and application of autologous blood concentrate product
Oral Surgery
D7111 Extraction, coronal remnants – primary tooth
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220 Removal of impacted tooth - soft tissue
D7230 Removal of impacted tooth - partially bony
D7240 Removal of impacted tooth - completely bony
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications
D7250 Removal of residual tooth roots (cutting procedure)
D7251 Coronectomy – intentional partial tooth removal, impacted teeth only
D7270 Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Exposure of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7471 Removal of lateral exostosis (maxilla or mandible)
D7510 Incision and drainage of abscess - intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7971 Excision of pericoronal gingiva
D7999 Unspecified oral surgery procedure, by report

Class C Major

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.
- Alternate benefits - if more than one service can be used to treat your dental conditions, we may decide to authorize alternate treatment coverage only for less costly covered service provided that the service selected must be deemed by the dental profession to be an appropriate method of treatment. If you and your dentist choose the more expensive treatment, you are responsible for the additional charges beyond the allowance for the alternate service, even if services are provided by an in-network provider.
- In-progress treatment for dependents of retiring TDP enrollees will be covered for the 2025 plan year. This is regardless of any current plan exclusions for care initiated prior to the enrollee's effective date.

High Option - You Pay:

- There is no deductible.
- The annual benefit maximum is unlimited In-Network or $2,000 Out-of-Network per covered person for Class A, B and C services. Note: In-Network and Out-of-Network amounts cross apply. Once the $2,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement.
- **In-Network:** 60% of our network allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 60% of the plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Standard Option - You Pay:

- **In-Network calendar year deductible:** $50 Self Only, $100 Self Plus One and $100 Self and Family. All individuals within Self Plus One and Self and Family plans will not pay more than a $50 deductible until the $100 family deductible is satisfied.
- **Out-of-Network calendar year deductible:** $100 Self Only, $200 Self Plus One and $200 Self and Family. All individuals within Self Plus One and Self and Family plans will not pay more than a $100 deductible until the $200 family deductible is satisfied.
- The deductible applies to both Intermediate (class B) and Major services (class C). Note: In-Network and Out-of-Network amounts cross apply.
- The annual benefit maximum is $1,500 In-Network or $1,000 Out-of-Network per covered person for Class A, B and C services. Note: In-Network and Out-of-Network amounts cross apply. Once the $1,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement up to the $1,500 maximum.
- **In-Network:** 65% of our plan allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 70% of our plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Major Restorative Services

D2510 Inlay - metallic - one surface - *An alternate benefit will be provided*

D2520 Inlay - metallic - two surfaces - *An alternate benefit will be provided*

D2530 Inlay - metallic - three or more surfaces - *An alternate benefit will be provided*

D2542 Onlay - metallic - two surfaces

D2543 Onlay - metallic - three surfaces

D2544 Onlay - metallic - four or more surfaces

D2740 Crown - porcelain/ceramic - *An alternate benefit will be provided on posterior teeth*

D2750 Crown - porcelain fused to high noble metal - *An alternate benefit will be provided*

D2751 Crown - porcelain fused to predominantly base metal - *An alternate benefit will be provided on posterior teeth*

D2752 Crown - porcelain fused to noble metal - *An alternate benefit will be provided on posterior teeth*

D2753 Crown - porcelain fused to titanium and titanium alloys

D2780 Crown - 3/4 cast high noble metal - *An alternate benefit will be provided on posterior teeth*

D2781 Crown - 3/4 cast predominantly base metal

D2782 Crown - 3/4 cast noble metal

D2783 Crown - 3/4 porcelain/ceramic - *An alternate benefit will be provided on posterior teeth*

D2790 Crown - full cast high noble metal - *An alternate benefit will be provided on posterior teeth*

D2791 Crown - full cast predominantly base metal

D2792 Crown - full cast noble metal

D2794 Crown - titanium and titanium alloys - *An alternate benefit will be provided on posterior teeth*

D2950 Core buildup, including any pins when required

D2954 Prefabricated post and core in addition to crown

D2980 Crown repair necessitated by restorative material failure

D2981 Inlay repair necessitated by restorative material failure

D2982 Onlay repair necessitated by restorative material failure

D2983 Veneer repair necessitated by restorative material failure

Not covered:

- *Gold foil restorations*
- *Sedative restorations*
- *Restorations for cosmetic purposes only*
- *Porcelain/Ceramic inlays, Composite resin inlays*
- *Porcelain/Ceramic onlays, Composite resin onlays*
- *Cast or processed restorations and crowns for purposes other than treatment for decay or acute traumatic injury, when teeth can be restored with a filling material*
- *Replacement of existing dentures, casts and processed restorations, crowns, removable dentures, fixed bridgework, or other covered prosthetic services that had been installed less than five years prior to the current replacement*

Endodontic Services

D3310 Endodontic therapy, anterior tooth (excluding final restoration)

D3320 Endodontic therapy, premolar tooth (excluding final restoration)

D3330 Endodontic therapy, molar tooth (excluding final restoration)

D3346 Retreatment of previous root canal therapy - anterior

D3347 Retreatment of previous root canal therapy - premolar

D3348 Retreatment of previous root canal therapy - molar

D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)

D3352 Apexification/recalcification – interim medication replacement

Endodontic Services - continued on next page

Endodontic Services (cont.)
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)
D3410 Apicoectomy - anterior
D3421 Apicoectomy - premolar (first root)
D3425 Apicoectomy - molar (first root)
D3426 Apicoectomy (each additional root)
D3430 Retrograde filling - per root
D3450 Root amputation - per root
D3471 Surgical repair of root resorption - anterior
D3472 Surgical repair of root resorption – premolar
D3473 Surgical repair of root resorption – molar
D3920 Hemisection (including any root removal), not including root canal therapy
Periodontal Services
D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant - *Limited to once in a 36 month period*
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant - *Limited to once in a 36 month period*
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant
D4249 Clinical crown lengthening – hard tissue
D4260 Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant - *Limited to once in a 36 month period*
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 once in a 36 month period*
D4268 Surgical revision procedure, per tooth
D4270 Pedicle soft tissue graft procedure
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft
D4276 Combined connective tissue and pedicle graft, per tooth
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft
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
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
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
D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - *Limited to once per lifetime*
D4999 Unspecified periodontal procedure, by report

Prosthodontic Services
D5110 Complete denture - maxillary
D5120 Complete denture - mandibular
D5130 Immediate denture - maxillary
D5140 Immediate denture - mandibular
D5211 Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)
D5212 Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5225 Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)
D5226 Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)
D5227 Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)
D5228 Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)
D5282 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary
D5283 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular
D5284 Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant
D5286 Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant
Note: *An* ***implant*** *is a covered procedure of the plan only if determined to be a dental necessity. Aetna claim review is conducted by a panel of licensed dentists who review the clinical documentation submitted by your treating dentist. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.*
D6010 Surgical placement of implant body: endosteal implant
D6013 Surgical placement of mini implant
D6040 Surgical placement: eposteal implant
D6050 Surgical placement: transosteal implant
D6055 Connecting bar – implant supported or abutment supported
D6056 Prefabricated abutment – includes modification and placement
D6057 Custom fabricated abutment – includes placement
D6058 Abutment supported porcelain/ceramic crown
D6059 Abutment supported porcelain fused to metal crown (high noble metal) - *An alternate benefit will be provided*
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal) - *An alternate benefit will be provided on posterior teeth*
D6061 Abutment supported porcelain fused to metal crown (noble metal) - *An alternate benefit will be provided on posterior teeth*
D6062 Abutment supported cast metal crown (high noble metal) - *An alternate benefit will be provided*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6063 Abutment supported cast metal crown (predominantly base metal)
D6064 Abutment supported cast metal crown (noble metal)
D6065 Implant supported porcelain/ceramic crown - *An alternate benefit will be provided on posterior teeth*
D6066 Implant supported crown – porcelain fused to high noble alloys - *An alternate benefit will be provided*
D6067 Implant supported crown – high noble alloys - *An alternate benefit will be provided*
D6068 Abutment supported retainer for porcelain/ceramic FPD - *An alternate benefit will be provided*
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal) - *An alternate benefit will be provided*
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) - *An alternate benefit will be provided on posterior teeth*
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal) - *An alternate benefit will be provided on posterior teeth*
D6072 Abutment supported retainer for cast metal FPD (high noble metal) - *An alternate benefit will be provided*
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074 Abutment supported retainer for cast metal FPD (noble metal)
D6075 Implant supported retainer for ceramic FPD - *An alternate benefit will be provided*
D6076 Implant supported retainer for FPD – porcelain fused to high noble alloys - *An alternate benefit will be provided*
D6077 Implant supported retainer for metal FPD – high noble alloys - *An alternate benefit will be provided*
D6080 Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments
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
D6082 Implant supported crown – porcelain fused to predominantly base alloys
D6083 Implant supported crown – porcelain fused to noble alloys
D6084 Implant supported crown - porcelain fused to titanium and titanium alloys
D6086 Implant supported crown – predominantly base alloys
D6087 Implant supported crown – noble alloys
D6088 Implant supported crown – titanium and titanium alloys
D6089 Accessing and retorquing loose implant screw - per screw
D6090 Repair of implant/abutment supported prosthesis
D6091 Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment
D6094 Abutment supported crown - titanium and titanium alloys
D6096 Remove broken implant retaining screw
D6097 Abutment supported crown – porcelain fused to titanium and titanium alloys
D6098 Implant supported retainer – porcelain fused to predominantly base alloys
D6099 Implant supported retainer for FPD – porcelain fused to noble alloys
D6100 Surgical removal of implant body
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
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
D6104 Bone graft at time of implant placement
D6105 Removal of implant body not requiring bone removal or flap elevation
D6110 Implant /abutment supported removable denture for edentulous arch – maxillary
D6111 Implant /abutment supported removable denture for edentulous arch – mandibular

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6112 Implant /abutment supported removable denture for partially edentulous arch – maxillary
D6113 Implant /abutment supported removable denture for partially edentulous arch – mandibular
D6114 Implant /abutment supported fixed denture for edentulous arch – maxillary
D6115 Implant /abutment supported fixed denture for edentulous arch – mandibular
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular
D6120 Implant supported retainer – porcelain fused to titanium and titanium alloys
D6121 Implant supported retainer for metal FPD – predominantly base alloys
D6122 Implant supported retainer for metal FPD – noble alloys
D6123 Implant supported retainer for metal FPD – titanium and titanium alloys
D6180 Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments
D6191 Semi-precision abutment – placement
D6193 Replacement of an implant screw
D6194 Abutment supported retainer crown for FPD – titanium and titanium alloys
D6195 Abutment supported retainer – porcelain fused to titanium and titanium alloys
D6205 Pontic - indirect resin based composite - *An alternate benefit will be provided on posterior teeth*
D6210 Pontic - cast high noble metal - *An alternate benefit will be provided on posterior teeth*
D6211 Pontic - cast predominantly base metal
D6212 Pontic - cast noble metal
D6214 Pontic - titanium and titanium alloys - *An alternate benefit will be provided on posterior teeth*
D6240 Pontic - porcelain fused to high noble metal - *An alternate benefit will be provided on posterior teeth*
D6241 Pontic - porcelain fused to predominantly base metal - *An alternate benefit will be provided on posterior teeth*
D6242 Pontic - porcelain fused to noble metal - *An alternate benefit will be provided on posterior teeth*
D6243 Pontic – porcelain fused to titanium and titanium alloys
D6245 Pontic - porcelain/ceramic - *An alternate benefit will be provided on posterior teeth*
D6545 Retainer - cast metal for resin bonded fixed prosthesis
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis - *An alternate benefit will be provided on posterior teeth*
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces
D6604 Retainer inlay - cast predominantly base metal, two surfaces
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces
D6740 Retainer crown - porcelain/ceramic - *An alternate benefit will be provided on posterior teeth*
D6750 Retainer crown - porcelain fused to high noble metal - *An alternate benefit will be provided on posterior teeth*
D6751 Retainer crown - porcelain fused to predominantly base metal - *An alternate benefit will be provided on posterior teeth*
D6752 Retainer crown - porcelain fused to noble metal - *An alternate benefit will be provided on posterior teeth*
D6753 Retainer crown – porcelain fused to titanium and titanium alloys
D6780 Retainer crown - 3/4 cast high noble metal - *An alternate benefit will be provided on posterior teeth*
D6781 Retainer crown - 3/4 cast predominantly base metal
D6782 Retainer crown - 3/4 cast noble metal
D6783 Retainer crown - 3/4 porcelain/ceramic - *An alternate benefit will be provided on posterior teeth*
D6784 Retainer crown ¾ – titanium and titanium alloys
D6790 Retainer crown - full cast high noble metal - *An alternate benefit will be provided on posterior teeth*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6791 Retainer crown - full cast predominantly base metal
D6792 Retainer crown - full cast noble metal
D6794 Retainer crown - titanium and titanium alloys – *An alternate benefit will be provided on posterior teeth*
D7252 Partial extraction for immediate implant placement
D9932 Cleaning and inspection of removable complete denture, maxillary
D9933 Cleaning and inspection of removable complete denture, mandibular
D9934 Cleaning and inspection of removable partial denture, maxillary
D9935 Cleaning and inspection of removable partial denture, mandibular
D9999 Unspecified adjunctive procedure, by report

Not covered:

- Partial or full removable denture, fixed bridgework or other covered prosthetic services (including implant abutments/ crowns) if it includes replacement of one or more natural teeth missing prior to you being covered under a participating FEDVIP plan or the prior TRDP plan. This does not apply if it also includes replacement of a natural tooth that is removed while you are covered and was not an abutment to a prosthetic appliance installed during the prior five years
- Precision attachments, personalization, precious metal bases, and other specialized technique
- Replacement of existing dentures, casts and processed restorations, crowns, removable dentures, fixed bridgework, or other covered prosthetic services that had been installed less than five years prior to the current replacement
- Replacement of dentures that have been lost, stolen or misplaced
- Removable or fixed prostheses inserted/cemented after the coverage ending date. This does not apply to prostheses that were initiated during the coverage period and inserted/cemented within 30 days of the coverage ending date.
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correction attrition, abrasion, or erosion.

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.
- Alternate benefits - if more than one service can be used to treat your dental conditions, we may decide to authorize alternate treatment coverage only for less costly covered service provided that the service selected must be deemed by the dental profession to be an appropriate method of treatment. If you and your dentist choose the more expensive treatment, you are responsible for the additional charges beyond the allowance for the alternate service, even if services are provided by an in-network provider.
- In-progress treatment for dependents of retiring TDP enrollees will be covered for the 2025 plan year. This is regardless of any current plan exclusions for care initiated prior to the enrollee's effective date.
- Comprehensive orthodontia treatment claims are paid in quarterly installments during the length of the treatment plan.

High Option - You Pay:

- There is no deductible.
- There is no waiting period for any benefits on this plan.
- The lifetime maximum for orthodontic services is $2,000.
- **In-Network:** 50% of our network allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 50% of our plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Standard Option - You Pay:

- There is no deductible for Class D services.
- There is no waiting period for any benefits on this plan.
- The lifetime maximum for orthodontic services is $2,000.
- **In-Network:** 50% of our network allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 50% of our plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Orthodontic Services

D0340 2D cephalometric radiographic image – acquisition, measurement and analysis
D0350 2D oral/facial photographic image obtained intra-orally or extra-orally
D0396 3D printing of a 3D dental surface scan
D0470 Diagnostic casts
D0702 2-D cephalometric radiographic image – image capture only
D0703 2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only
D0801 3D intraoral surface scan – direct
D0802 3D dental surface scan – indirect
D0803 3D facial surface scan – direct

Orthodontic Services - continued on next page

Orthodontic Services (cont.)
D0804 3D facial surface scan – indirect
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
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment examination to monitor growth and development
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))
D8681 Removable orthodontic retainer adjustment
Not covered: • *Repair of damaged orthodontic appliances* • *Replacement of lost or missing appliance* • *Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correction attrition, abrasion, or erosion.* • *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*

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.
- Alternate benefits - if more than one service can be used to treat your dental conditions, we may decide to authorize alternate treatment coverage only for less costly covered service provided that the service selected must be deemed by the dental profession to be an appropriate method of treatment. If you and your dentist choose the more expensive treatment, you are responsible for the additional charges beyond the allowance for the alternate service, even if services are provided by an in-network provider.

High Option - You Pay:

- There is no deductible.
- The annual benefit maximum is unlimited In-Network or $2,000 Out-of-Network per covered person for Class A, B and C services. Note: In-Network and Out-of-Network amounts cross apply. Once the $2,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement.

Anesthesia Services and Intravenous Sedation

- **In-Network:** 60% of our network allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 60% of the plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Medications, Post-Surgical Services and Miscellaneous Services

- **In-Network:** 30% of our network allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 40% of the plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist

Standard Option - You Pay:

- **In-network calendar year deductible:** $50 Self Only, $100 Self Plus One and $100 Self and Family. All individuals within Self Plus One and Self and Family plans will not pay more than a $50 deductible until the $100 family deductible is satisfied.
- **Out-of-network calendar year deductible:** $100 Self Only, $200 Self Plus One and $200 Self and Family. All individuals within Self Plus One and Self and Family plans will not pay more than a $100 deductible until the $200 family deductible is satisfied.
- The deductible applies to General services in this section. Note: In-Network and Out-of-Network amounts cross apply.
- The annual benefit maximum is $1,500 In-Network or $1,000 Out-of-Network per covered person for Class A, B and C services. Note: In-Network and Out-of-Network amounts cross apply. Once the $1,000 has been paid for in or out-of-network services, only in-network claims are eligible for reimbursement up to the $1,500 maximum.

Anesthesia Services and Intravenous Sedation

- **In-Network:** 65% of our network allowance. You are not responsible for charges above our network allowance when you use a network dentist.

- **Out-of-Network:** 70% of the plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

Medications, Post-Surgical Services and Miscellaneous Services

- **In-Network:** 45% of our network allowance. You are not responsible for charges above our network allowance when you use a network dentist.
- **Out-of-Network:** 70% of the plan allowance when you use a non-network dentist. You will be responsible for the difference between the plan payment and the amount billed by the dentist

Anesthesia Services

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia

D9222 Deep sedation/general anesthesia – first 15 minutes

D9223 Deep sedation/general anesthesia – each subsequent 15 minute increment

Intravenous Sedation

D9239 Intravenous moderate (conscious) sedation/analgesia- first 15 minutes

D9243 Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment

Medications

D9610 Therapeutic parenteral drug, single administration

D9612 Therapeutic parenteral drugs, two or more administrations, different medications

D9613 Infiltration of sustained release therapeutic drug, per quadrant

Post-Surgical Services

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

Miscellaneous Services

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

D9943 Occlusal guard adjustment

D9944 Occlusal guard – hard appliance, full arch - *Limited to once in a 36 month period*

D9945 Occlusal guard – soft appliance, full arch - *Limited to once in a 36 month period*

D9946 Occlusal guard – hard appliance, partial arch - *Limited to once in a 36 month period*

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

Not covered:

- *Nitrous oxide*
- *Oral sedation*
- *General anesthesia and IV sedation unless determined to be medically necessary and unless done in conjunction with another necessary covered service*

Section 6 International Services and Supplies

International Claims Payment	If you receive dental services while overseas, you will need to submit your claims to Aetna. Upon receipt of the claim, Aetna 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. We do not have a participating dental network outside the U.S.
Filing International Claims	Please send us all of your documents for your claim to: Aetna P.O. Box 14094 Lexington, KY 40512-4094
Customer Service Website and Phone Numbers	You may look up information on our plan or ask a question at www.aetnafeds.com. (Our toll-free number will not work overseas).
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.** *Also, please see Section 5, Dental Services and Supplies, for other exclusions and limitations.*

We do not cover the following:

- Dental care services due to accidental injury that are covered by the medical plan, even when provided by a general dentist or oral surgeon;
- Any dental service or treatment not specifically listed as a covered service;
- Services or treatment provided by a member of your immediate family or a member of the immediate family of your spouse;
- 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 submitted by a dentist which are for the same services performed on the same day for the same member by another dentist;
- Services and treatment which are experimental or investigational;
- Services provided free of charge by any government unit, except where this exclusion is prohibited by law;
- 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 of any governmental unit. This exclusion applies whether or not you claim the benefits or compensation;
- Services and treatment 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 for which the member would have no obligation to pay in the absence of this or any other insurance;
- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;
- Services and treatment performed prior to your effective coverage date, except partial or full removable denture, fixed bridgework or other covered prosthetic services if it includes replacement of one or more natural teeth missing prior to you being covered under a participating FEDVIP plan or the prior TRDP plan;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatment which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist (Services determined to be unnecessary or which do not meet accepted standards of dental practice are not billable to you by a participating dentist unless the dentist notifies you of your liability prior to treatment and you choose to receive the treatment. Participating dentists should document such notification in their records.);
- Services and treatment not meeting accepted standards of dental practice;
- Services performed by a dentist who is compensated by a facility for similar covered services performed for members;
- Services and treatment resulting from your failure to comply with professionally prescribed treatment;
- Services which are for unusual procedures or techniques;
- Services related to diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD);
- 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 images, or any costs associated with forwarding/mailing copies of your records, charts or images;
- State or territorial taxes on dental services performed;
- 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;
- Hospital costs or any additional fees that the dentist or hospital charges are for treatment at the hospital (inpatient or outpatient);
- Adjunctive dental care services that are covered by other medical insurance even when provided by a general dentist or oral surgeon;
- 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;
- Duplicate and temporary devices, appliances, and services;

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

To obtain claim forms or other claim filing advice or answers about your benefits, contact us at 1-800-537-9384 or go to our web site at www.aetnafeds.com.

Deadline for Filing Your Claim

Send us all of the documents for your claim, as soon as possible, to: Aetna, PO Box 14094, Lexington, KY 40512-4094.

You must submit claims by December 31 of the year after the year you received the service unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as possible. Once we pay the benefits, there is a two-year limitation on the reissuance of uncashed checks.

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.**

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

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at: Aetna, Attention: National Accounts, P.O. Box 14597, Lexington, KY 40512-4597; and

Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. This is your first level appeal.

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

a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or

b) Write to you and maintain our denial – go to step 3; or

c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

3. If the dispute is not resolved through the reconsideration process, and the reason for the denial was based on medical necessity or for experimental or investigational reasons, you have the right to file a second level appeal. That appeal must be submitted within 60 days following the receipt of our first level denial.

4. If you do not agree with our final decision, and the amount of your claim is more than $300 and the plan denied your claim because it did not consider the treatment medical necessity, you may request an independent third party, mutually agreed upon by us and OPM, review the decision. You have 30 days from the date you received our final decision to request a third party review.

The decision of the independent third party is binding and is the final review of your claim. This decision is not subject to judicial review.

Section 9 Definitions of Terms We Use in This Brochure

Alternate Benefit	If more than one service or procedure can be used to treat the covered person's dental condition, Aetna may decide to authorize coverage only for the less costly covered service or procedure when that service is deemed by the dental profession to be an appropriate method of treatment and the service selected must meet broadly accepted national standards of dental practice. If you and your dentist choose the more expensive treatment, you are responsible for the additional charges beyond the allowance for the alternate service, even if services are provided by an in-network provider.
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.
Class A Services	Basic services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and images.
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.
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	Services that are customarily used nationwide and "deemed by the profession to be appropriate". They must meet broadly accepted national standards of practice.
In-Progress-Treatment	Dental services that initiated in 2024 that will be completed in 2025.
Plan Allowance	Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Network provider plans determine their allowance in different ways. We determine our allowance as follows: **High option:** • Network Providers – we negotiate rates with doctors, dentists and other health care providers to help save you money. We refer to these providers as "network providers". These negotiated rates are our Plan allowance for network providers. We calculate a member's coinsurance using these negotiated rates. The member is not responsible for amounts billed by network providers that are more than our Plan allowance.

- Non-Network providers – Providers that do not participate in our networks are considered non-network providers. Because they are out of our network, we pay for out-of-network services based on the out-of-network Plan allowance. To figure out the out-of-network Plan allowance, we get information from FAIR Health. Health plans send FAIR Health claims data for services they receive from providers. FAIR Health combines this information into databases that show how much providers charge for services by zip code. Providers' charges for specific procedures are grouped in percentiles from low to high. We use the 80th percentile as the Plan allowance to calculate how much to pay for out of network services. The 80th percentile means 80 percent of charges in the database are the same or less for that service in a particular area. We use the Plan allowance when calculating a member's coinsurance amount. The member is responsible for any amounts billed by the non-network provider that are above the Plan allowance, plus their coinsurance amount.

Standard option:

- Network Providers – we negotiate rates with doctors, dentists and other health care providers to help save you money. We refer to these providers as "Network providers". These negotiated rates are our Plan allowance for network providers. We calculate a member's coinsurance using these negotiated rates. The member is not responsible for amounts billed by network providers that are greater than our Plan allowance.
- Non-Network providers – Providers that do not participate in our networks are considered non-network providers. Our Plan allowance for out-of-network services is based on the in-network negotiated fee for the area. While network providers accept the negotiated fee, members may be billed by out-of-network providers for the difference between the Plan allowance and the provider's fee.

Pre-Certification

This is the procedure used by the plan to pre-approve services and the amount that the plan will cover.

Sponsor

Generally, a sponsor means the individual who is eligible for medical or dental benefits under 10 U.S.C. chapter 55 based on their direct affiliation with the uniformed services (including military members of the National Guard and Reserves).

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.

Tooth Missing but Not Replaced Rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while covered under a participating FEDVIP plan or the prior TRDP plan; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. The extraction of third molars does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Waiting Period

High Option: There is no waiting period for any benefits on this plan option.
Standard Option: There is no waiting period for any benefits on this plan option.

We/Us	Aetna Dental
You	Enrollee or eligible family member.

Non-FEDVIP Benefits Available to Plan Members

The benefits on this page are not part of the FEDVIP contract or premium, and you cannot file an FEDVIP disputed claim about them. Fees you pay for these services do not count towards any FEDVIP maximums.

Aetna Vision℠ Discounts

Save on eyewear and eye exams just for being an Aetna member. You can visit many doctors in private practice. Plus, national chains like LensCrafters®, CVS Optical®, Target Optical®, Pearle Vision® and more. To find vision discount provider locations, log into the Aetna®member website from www.aetnafeds.com and select discounts. Or call 1-800-793-8616.

Aetna Member Website

Aetna member website, our secure member self service website, provides you with the tools and personalized information to help you manage your health. Click on "Member Login/Register" from www.aetnafeds.com to register and access a secure, personalized view of your Aetna benefits.

You can:

- Review PCP selections
- Print temporary ID cards
- Download details about a claim such as the amount paid and the member's responsibility
- Contact member services at your convenience through secure messages
- Access cost and quality information through Aetna's transparency tools
- View and update your Personal Health Record
- Find information about the member extras that come with your plan
- Access health information through Aetna Healthwise® Knowledgebase

Registration assistance is available toll free, Monday through Friday, from 7am to 9pm Eastern Time at 1-800-225-3375. Register today at www.aetnafeds.com.

Stop Healthcare Fraud!

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, plan, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your 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 1-800-537-9384 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 he/she is 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.

Summary of Benefits

- ***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 number 1-877-889-5680.*
- *There is no deductible.*

	You Pay	
High Option Benefits	**In-Network**	**Out-of-Network**
Class A (Basic) Services – preventive and diagnostic	Nothing	10%
Class B (Intermediate) Services – includes minor restorative services	30%	40%
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	60%	60%
Annual maximum benefit - applies to Class A, B, and C Services	Unlimited	$2,000
Class D Services – orthodontic $2,000 Lifetime Maximum	50%	50%
Standard Option Benefits	**In-Network**	**Out-of-Network**
Deductible	$50 self only; $100 self plus or self and family (applies only to Class B and C services)	$100 self only; $200 self plus or self and family (applies only to Class B and C services)
Class A (Basic) Services – preventive and diagnostic	Nothing	40%
Class B (Intermediate) Services – includes minor restorative services	45%	70%
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	65%	70%
Annual maximum benefit - applies to Class A, B, and C Services	$1,500	$1,000
Class D Services – orthodontic $2,000 Lifetime Maximum Plan payment percentages are applied to the plan allowance. When you use an out-of-network provider, in addition to your coinsurance percentage, you are responsible for the difference between the plan allowance and the billed charges.	50%	50%

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 next page, match your rating area to your enrollment type and plan option.

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

State	Zip	Rating Region	State	Zip	Rating Region	State	Zip	Rating Region
AK	entire state	5	KY	410, 459	2	OH	430-433, 437, 440-443, 446-447, 450-455, 459	2
AL	356-358	1	KY	rest of state	1	OH	rest of state	3
AL	rest of state	2	LA	entire state	2	OK	entire state	2
AR	entire state	2	MA	12	4	OR	970-973	4
AZ	864	2	MA	rest of state	5	OR	rest of state	5
AZ	rest of state	3	MD	entire state	2	PA	150-154, 156-157, 160, 162	1
CA	900-908, 910-928, 930-931, 933-935	3	ME	entire state	5	PA	172-174, 189-196	2
CA	rest of state	4	MI	entire state	3	PA	rest of state	3
CO	entire state	3	MN	550-551, 553-555, 563	2	PR	entire state	3
CT	060-063	5	MN	rest of state	3	RI	entire state	5
CT	064-069	3	MO	726	2	SC	entire state	4
DC	entire state	2	MO	rest of state	3	SD	entire state	3
DE	entire state	2	MS	entire state	2	TN	entire state	1
FL	330-334, 349	2	MT	entire state	4	TX	entire state	2
FL	rest of state	3	NC	279	3	UT	entire state	2
GA	300-303, 305-306, 311, 399	3	NC	rest of state	4	VA	201-205, 220-227	2
GA	rest of state	4	ND	entire state	3	VA	rest of state	3
GU	entire area	5	NE	entire state	1	VI	entire area	2
HI	entire state	4	NH	entire state	5	VT	entire state	5
IA	515	1	NJ	rest of state	3	WA	986	4
IA	rest of state	3	NJ	080-084	2	WA	rest of state	5
ID	entire state	4	NM	entire state	3	WI	540	2
IL	600-609, 613	2	NV	897	4	WI	rest of state	3
IL	rest of state	3	NV	rest of state	2	WV	254	2
IN	460-464, 470, 472-473	2	NY	63	5	WV	rest of state	4
IN	rest of state	3	NY	005, 100-119, 124-126	3	WY	entire state	4
KS	entire state	3	NY	rest of state	4	Int'l	International	2

Bi-Weekly & Monthly Rates

Find your rating area on the previous page.

Rating Area	High - Bi-Weekly			High - Monthly		
	Self Only	Self Plus One	Self and Family	Self Only	Self Plus One	Self and Family
1	$17.62	$35.23	$52.85	$38.18	$76.33	$114.51
2	$19.41	$38.81	$58.22	$42.06	$84.09	$126.14
3	$20.64	$41.28	$61.92	$44.72	$89.44	$134.16
4	$22.78	$45.57	$68.35	$49.36	$98.74	$148.09
5	$24.75	$49.47	$74.21	$53.63	$107.19	$160.79

Rating Area	Standard - Bi-Weekly			Standard - Monthly		
	Self Only	Self Plus One	Self and Family	Self Only	Self Plus One	Self and Family
1	$10.57	$21.13	$31.70	$22.90	$45.78	$68.68
2	$11.63	$23.25	$34.86	$25.20	$50.38	$75.53
3	$12.36	$24.71	$37.06	$26.78	$53.54	$80.30
4	$13.61	$27.22	$40.83	$29.49	$58.98	$88.47
5	$14.78	$29.55	$44.34	$32.02	$64.03	$96.07

Aetna Vision℠ Preferred

www.aetnafeds.com

1-855-347-6899

aetna®

2025

A Nationwide Vision Plan, available nationwide and overseas

IMPORTANT
- Rates: Back Cover
- Changes for 2025: Page 4
- Summary of Benefits: Page 23

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 Aetna Vision under Aetna Life Insurance Company's contract OPM02-FEDVIP-02AP-02 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

Aetna Vision
Federal Plans
PO Box 818047
Cleveland, OH 44181-8047
1-855-347-6899
www.aetnafeds.com

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your benefits. You and your family members do not have a right to benefits that were available before January 1, 2025, unless those benefits are also shown in this brochure.

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated 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.

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

Aetna is responsible for the selection of in-network providers in your area. Contact us 1-855-347-6899 for the names of participating providers or to request a provider directory. You may also request or view the most current directory via our website at www.aetnafeds.com. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not on a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in-network. If your provider is not currently participating in the provider network, you can nominate them to join. Please print off a nomination form from our website at www.aetnafeds.com or call us and we will have a form sent to you. Bring the form to your provider and ask them to complete it if they are interested in participating in our network. You cannot change plans, outside of open season, because of changes to the provider network.

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

This Aetna 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.

Discrimination is Against the Law

Aetna 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, Aetna 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 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.

How We Have Changed For 2025

Changes to the High Option include:

- There are no plan changes for 2025.

Changes to the Standard Option include:

- There are no plan changes 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, Postal Service Health Benefits (PSHB) Program, or the Health Insurance Marketplace (Exchange) and your position is not excluded by law or regulation. Enrollment in the FEHB Program, PSHB Program, or a Health Insurance Marketplace (Exchange) plan is not required.

Temporary/Seasonal Employees

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

Federal Annuitants

You are eligible to enroll if you:

- retired on an immediate annuity under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS), or another retirement system for employees of the Federal Government;
- retired for disability under CSRS, FERS, or another retirement system for employees of the Federal Government.

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

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

Survivor Annuitants

If you are a survivor of a deceased Federal/U.S. Postal Service employee or annuitant and you are receiving an annuity, you may enroll or continue the existing enrollment.

Compensationers

A compensationer is someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation Programs (OWCP) due to an on-the-job injury/illness who is determined by the Secretary of Labor to be unable to return to duty. You are eligible to enroll in FEDVIP or continue FEDVIP enrollment into compensation status.

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, FEHB/PSHB rules for family member eligibility are **NOT** the same. For more information on family member eligibility visit the website at www.opm.gov/healthcare-insurance/dental-vision/ or contact your employing agency or retirement system.

With respect to TRICARE-eligible individuals, family members include your spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in your legal custody by a court. An unremarried former spouse who meets the U.S. Department of Defense's 20-20-20 and/or 20-20-15 benefit eligibility requirements may only enroll in a self-only FEDVIP vision plan. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.

Not Eligible

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

- Deferred annuitants
- Former spouses of employees or annuitants. **Note:** Former spouses of TRICARE-eligible individuals may enroll in a FEDVIP vision plan.
- FEHB/PSHB Temporary Continuation of Coverage (TCC) enrollees
- Anyone receiving an insurable interest annuity who is not also an eligible family member
- Active duty uniformed service members. **Note:** If you are an active duty uniformed service member, your dental and vision coverage will be provided by TRICARE. Your family members will still be eligible to enroll in the TRICARE Dental Plan (TDP).
- Temporary/seasonal employees who 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 a FEDVIP vision plan and want to switch to Aetna Vision, you must change enrollment through BENEFEDS. If you do not want to change plans or options, your enrollment will continue automatically. Please note: your 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 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 (enrollee deployment), Yes (spouse deployment)
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 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 and confirms the enrollment or change. BENEFEDS will send you confirmation of your new coverage effective date.

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

VA Exception for Cancellation

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

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

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

FEDVIP enrollees can verify if they are paying their premiums on a pre- or post- tax basis by contacting BENEFEDS at 1-877-888-3337, 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 plans:

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

FSAFEDS/High Deductible Health Plans and FEDVIP

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

Please review IRS - Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans (www.irs.gov/forms-pubs/about-publication-969) for additional information about carryover and contribution amounts for the upcoming tax year. If you have an HCFSA or LEX HCFSA FSAFEDS account and you have not exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over a set maximum amount of unspent funds into another health care or limited expense account for the subsequent year. To be eligible for carryover, you must be employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st. You must also actively re-enroll in a health care or limited expense account during the next open season to be carryover eligible. Your reenrollment must meet the minimum contribution amount for the plan year. If you do not reenroll, or if you are not employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st, your funds will not be carried over.

Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense and file a claim in the time 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.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-866-353-8058. **Note: FSAFEDS is not open to retired employees or to TRICARE eligible individuals.**

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you 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	ID cards are not provided and are not required to obtain service. We will send you an enrollment confirmation letter when you enroll. For members who wish to carry an ID card, you may print a copy online from our Aetna Member website or call customer service at 1-855-347-6899 to verify your eligibility in the plan. If you are enrolled in an FEHB/PSHB plan it is important to bring your FEHB/ PSHB identification card to every vision appointment because most FEHB/PSHB plans offer some level of vision benefits separate from your FEDVIP coverage. Presenting both identification cards can ensure that you receive the maximum allowable benefit under each Program.
Plan Providers	We list plan providers in the provider directory, which is updated nightly. The provider directory is on our website www.aetnafeds.com. It is your responsibility to ensure that the provider chosen is an active participant in the program at the time you receive services. The Aetna Vision Preferred network is specific to routine vision care and is different from the network for the Aetna medical plan. In some cases, due to local regulations or business practices, the doctor may be independent of the retail location. You should confirm that both the doctor and the retail location are participating prior to seeking services.
In-Network	We negotiate rates with vision care providers and other health care providers to help save you money. Aetna Vision Preferred in-network providers are contracted through EyeMed Vision Care. When scheduling an appointment, you should identify yourself as a member of the FEDVIP Aetna Vision Preferred plan. The provider is then responsible for verifying eligibility by contacting Aetna Vision Preferred either by telephone or via the web. We refer to these providers as "In-Network providers". If you use in-network providers to obtain covered care, benefits are paid at the in-network level. You are responsible for covered charges up to our negotiated plan allowance.
Out-of-Network	You may obtain care from any licensed eye care provider. If the provider you use is not part of our network, benefits will be considered out-of-network. Because these providers are out of our network, we will reimburse you up to the maximum reimbursement amount allowed by the plan. You are responsible to pay the out-of-network provider and then submit a claim to receive your reimbursement.
Pre-Authorization	Pre-authorization is not required.
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. We are responsible for facilitating the process with the primary FEHB/PSHB payor. It is important to bring your FEDVIP and FEHB/PSHB identification cards to every vision appointment because most FEHB/PSHB plans offer some level of vision benefits separate from your FEDVIP coverage. Presenting both identification cards can ensure that you receive the maximum allowable benefit under each Program.
Coordination of Benefits	**IF:** You have medical coverage through FEHB/PSHB and Aetna's FEDVIP vision plan **THEN:** Present your FEHB/PSHB ID card at the time of service as the FEHB/PSHB plan will pay benefits first **IF:** You have vision coverage through a non-FEHB/non-PSHB plan and Aetna Vision coverage under FEDVIP (covered through a spouse) **THEN:** Aetna Vision is the primary payor and your non-FEHB/non-PSHB plan is secondary

IF: If your **covered dependent child** has coverage through a non-FEHB/non-PSHB plan and Aetna Vision coverage under FEDVIP.
THEN: The parent's plan whose birthday occurs first in the calendar year (1. Month, 2. Date) is primary. If the months and dates are the same for both parents, the primary payor is the plan that has provided coverage the longest.

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

Limited Access Areas

If you live in an area with limited access to a network provider and you receive covered services from an out-of-network provider, we will pay the same benefit level as if you utilized the services of an in-network provider. You are responsible for any difference between the amount billed and our payment. Call us 1-855-347-6899, if you are having problems locating a provider in your area.

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

Services/Material: Exam
Standard Option We Pay: Up to $40
High Option We Pay: Up to $40

Services/Material: Single Vision Lenses
Standard Option We Pay: Up to $40
High Option We Pay: Up to $40

Services/Material: Bifocal Lenses
Standard Option We Pay: Up to $60
High Option We Pay: Up to $60

Services/Material: Trifocal Lenses
Standard Option We Pay: Up to $80
High Option We Pay: Up to $80

Services/Material: Lenticular Lenses
Standard Option We Pay: Up to $80
High Option We Pay: Up to $80

Services/Material: Contact Lenses
Standard Option We Pay: Up to $120
High Option We Pay: Up to $136

Services/Material: Medically Necessary Contact Lenses
Standard Option We Pay: Up to $210
High Option We Pay: Up to $210

Services/Material: Frames
Standard Option We Pay: Up to $80
High Option We Pay: Up to $150

Section 4 Your Cost for Covered Services

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

Co-payment

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

Example: In the Aetna Vision High Option plan, you pay a $0 co-pay for an exam.

In-Network Services

When you visit an Aetna Vision network doctor, your eye exam and prescription glasses or contacts are covered after any co-payments. You will also receive 20% off any out-of-pocket costs over your frame allowance and a savings of 15% on any balance over your conventional contact allowance.

Out-of-Network Services

If you choose to visit a non-participating provider, you will be reimbursed according to the following fee schedule allowances shown in the chart below. You are responsible for charges billed over the amounts shown.

Services/Material: Exam
Standard Option We Pay: Up to $40
High Option We Pay: Up to $40

Services/Material: Single Vision Lenses
Standard Option We Pay: Up to $40
High Option We Pay: Up to $40

Services/Material: Bifocal Lenses
Standard Option We Pay: Up to $60
High Option We Pay: Up to $60

Services/Material: Trifocal Lenses
Standard Option We Pay: Up to $80
High Option We Pay: Up to $80

Services/Material: Lenticular Lenses
Standard Option We Pay: Up to $80
High Option We Pay: Up to $80

Services/Material: Contact Lenses
Standard Option We Pay: Up to $120
High Option We Pay: Up to $136

Services/Material: Medically Necessary Contact Lenses
Standard Option We Pay: Up to $210
High Option We Pay: Up to $210

Services/Material: Frames
Standard Option We Pay: Up to $80
High Option We Pay: Up to $150

Please see Section 3, How You Obtain Care, for more information.

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.

- Both the High and Standard vision options include out-of-network benefit coverage. The out-of-network benefit structure is listed under the Summary of Benefits section.
- **Eyewear: You may choose prescription eyeglass lenses or contacts.**

Benefit Description	You Pay*	
Diagnostic	**High**	**Standard**
Eye examination - covered in full (once every calendar year). Participating doctors provide a comprehensive exam that focuses on your eyes and overall wellness, including dilation as necessary.	Nothing	Nothing
Retinal Imaging	Up to $39	Up to $39
Eyewear	**High**	**Standard**
Lenses: covered in full (once every calendar year) Standard Plastic single vision, lined bifocal, lined trifocal, and lenticular lenses **NOTE**: **You may choose prescription eyeglass lenses or contacts.**	Nothing	$10
Lens Options (covered in addition to base lens): Standard Polycarbonate lenses (shatter-resistant)	Nothing	Nothing
Lens Options (covered in addition to base lens): Standard Scratch resistant coating	Nothing	Nothing
Lens Options (covered in addition to base lens): Standard Anti-reflective coatings	$20	$45 fixed discount**
Premium Anti-reflective coatings tier 1	$32	$57 fixed discount **
Premium Anti-reflective coatings tier 2	$43	$68 fixed discount**
Premium Anti-reflective coatings tier 3	80% of retail price	80% of retail price
Lens Options (covered in addition to base lens): UV Protection and Tint (Solid or Gradient)	Nothing	$15 fixed discount**
Lens Options (covered in addition to base lens): Photochromic lenses- lenses are clear indoors and darken outside	$75 fixed discount**	$75 fixed discount**
Lens Options (covered in addition to base lens): Standard progressive lenses	Nothing	$75
Lens Options (covered in addition to base lens): Premium progressive lenses Tiers 1-3	$40-65	$95-120
Lens Options (covered in addition to base lens): Other premium progressive lenses	80% of charge less $120 allowance + $20 copay	80% of charge less $120 allowance + $75 copay

Eyewear - continued on next page

Benefit Description	You Pay*	
Eyewear (cont.)	**High**	**Standard**
Frames - once every calendar year Any frame available at the provider location	Nothing for frames up to the $300 plan allowance Frame Greater than $300: pay any amount after a 20% discount	Nothing for frames up to the $160 plan allowance Frame Greater than $160: pay any amount after a 20% discount
Contact Lens Fitting and Material	**High**	**Standard**
Standard Contact Lens Fit & Follow-up (includes applications of clear, soft, spherical, daily-wear contact lenses for single-vision prescriptions) - once every calendar year	$40 fixed discount**	$40 fixed discount**
Premium Contact Lens Fit & Follow-up (Includes the application of toric (astigmatism .62D or higher in the contact lens), multifocal/monovision, post-surgical and gas permeable lenses. This includes extended/ overnight wear for any prescription.) - once every calendar year	90% of retail price	90% of retail price
Conventional/Disposable contact lenses **You may choose prescription eyeglass lenses or contacts once every calendar year**	Nothing for Contact Lenses up to the $170 plan allowance You will receive a 15% discount off the cost over $170 for conventional contact lenses	Nothing for Contact Lenses up to the $150 plan allowance You will receive a 15% discount off the cost over $150 for conventional contact lenses
Medically necessary contact lenses **You may choose prescription eyeglass lenses or contacts once every calendar year** Contact lenses are medically necessary if you're diagnosed with one of these conditions (ask your eye doctor for more info): • Anisometropia of 3D in meridian powers • High Ametropia exceeding – 10D or +10D in meridian powers • Keratoconus when vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses • Vision improvement other than Keratoconus when vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses	Nothing	Nothing

* Please refer to Section 4, Your Cost for Covered Services, for the nationwide reimbursement schedule and Section 6, International Services and Supplies, for the international reimbursement schedule.

**The amount shown is the negotiated discounted price you will pay the provider. Not all providers participate in every plan or offer all services. Discounts on non-covered services may not be available through all providers, or in all states. Contact your provider to confirm available discounts.

Discounts and Features

- Hearing aids and exams - Save on hearing exams, a large choice of leading brand hearing aids, batteries and free routine follow-up services. There are two ways for you to save at thousands of locations through Hearing Care Solutions or Amplifon Hearing Health Care.
- Healthy lifestyle choices - Save on gym memberships, health coaching, fitness gear and nutrition products that support a healthy lifestyle. Get access to local and national discounts on brands you know. At-home weight-loss programs with tips and menus. Also save on wearable fitness devices, meditation, yoga, wellness programs and group fitness on demand.
- Natural products and services - Ease your stress and tension and save on therapeutic massage, acupuncture or chiropractic care. Get advice from registered dietitians with nutrition services. Save on popular products from health and fitness vendors, like blood pressure monitors, pedometers and activity trackers, devices for pain relief and many other products. Save on teeth whitening, electronic toothbrushes, replacement brush heads and various oral health care kits.

Getting started is easy, just log in to your member website at www.Aetnafeds.com, once you're an Aetna member.

Vision Discounts

The following extra discounts and savings are only available from network doctors.

Prescription glasses

- Minimum savings of 20% on all non-covered lens options.
- Up to 40% discount off additional pairs of prescription glasses and sunglasses.

Laser vision correction

Members will receive a discount of 15% off retail or 5% off promotional prices at providers in the US Laser network. The network offers over 600 locations including preferred featured providers like LasikPlus, TLC Laser Eye Centers and The LASIK Vision Institute. These featured providers offer specials throughout the year including free consultations and extra discounts on LASIK. The LASIK discount is only available from U.S. Laser Network by calling 1-800-422-6600 or visiting www.lasikdiscounts.com.

International travel solutions

No need to wonder about your eye care if you have a break abroad. Your benefit gives you access to a curated network of providers in more than 20 countries if you are traveling and emergency happens. Get emergency glasses delivered within 24 hours in most locations. It's free and doesn't count toward your benefit allowance. Each lens is adjustable, with a -6 to +3 diopter range. Just turn the range dial on the side of the frame to adjust for near, intermediate and distance vision. Find out more at www.www.aetnavision.com.

Vision Cost Estimator Tool

Understanding vision benefits can be confusing. That's why we made it easy for you to estimate your out-of-pocket costs ahead of time. See a list of services and products, choose your preferences and we'll estimate your savings and out-of-pocket costs based on your specific plan.

Vision Mobile App

Manage all your vision care needs on the go with the Aetna Vision Preferred app

- Find a network provider near you or check out your online provider options
- Get cost estimates before you go
- View your benefits
- See your next eligible date
- Track your prescription
- Access your member ID card whenever you need it and more

Section 6 International Services and Supplies

International Claims Payment

Aetna Vision is a nationwide vision plan and therefore does not have network doctors overseas. To obtain services, visit any international eye care provider and you will be reimbursed out-of-network schedule:

Services/Material: Exam
Standard Option We Pay: Up to $40
High Option We Pay: Up to $40

Services/Material: Single Vision Lenses
Standard Option We Pay: Up to $40
High Option We Pay: Up to $40

Services/Material: Bifocal Lenses
Standard Option We Pay: Up to $60
High Option We Pay: Up to $60

Services/Material: Trifocal Lenses
Standard Option We Pay: Up to $80
High Option We Pay: Up to $80

Services/Material: Lenticular Lenses
Standard Option We Pay: Up to $80
High Option We Pay: Up to $80

Services/Material: Contact Lenses
Standard Option We Pay: Up to $120
High Option We Pay: Up to $136

Services/Material: Medically Necessary Contact Lenses
Standard Option We Pay: Up to $210
High Option We Pay: Up to $210

Services/Material: Frames
Standard Option We Pay: Up to $80
High Option We Pay: Up to $150

Finding an International Provider

Visit the international eye care provider of your choice.

Filing International Claims

We have several convenient ways to submit a claim for reimbursement. You can download a claim form by going to www.aetnafeds.com, resources, claim forms and select Vision Claim form (for FEDVIP Aetna Vision Preferred Plan) and mail to the address on the form or go green and get paid faster by submitted electronically by accessing the online form.

Claim forms can be mailed to:

Aetna Vision
Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111

Customer Service Website and Phone Numbers

You may look up information on our plan or ask a question at www.aetnafeds.com. (Our toll-free number will not work overseas).

International Rates

Please refer to the Rate Information section, to view the rates. Premiums for our international members are the same as our nationwide members.

Section 7 General Exclusions – Things We Do Not Cover

The following services and materials are not covered:

- Any charges in excess of the benefit, dollar, or supply limits stated in this brochure;
- Any exams given during your stay in a hospital or other facility for medical care;
- Drugs or medicines;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Special vision procedures, such as orthoptics, vision therapy or vision training;
- Vision services or supplies which do not meet professionally accepted standards;
- Duplicate or spare eyeglasses or lenses or frames for them;
- Replacement of lost, stolen or broken **prescription** lenses or frames;
- Special supplies such as nonprescription sunglasses and subnormal vision aids;
- Any vision service, treatment or materials not specifically listed as a covered service;
- Services and materials that are experimental or investigational;
- Services and materials which are rendered prior to your effective date;
- Services and materials incurred after the termination date of your coverage unless otherwise indicated;
- Services and materials not meeting accepted standards of optometric practice;
- Services and materials resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services or materials provided as a result of intentionally self-inflicted injury or illness;
- Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- State or territorial taxes on vision services performed;
- Medical treatment of eye disease or injury;
- Special lens designs or coatings other than those described in this brochure;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals;
- Services not performed by licensed personnel;
- Prosthetic devices and services;
- Insurance of contact lenses;
- Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.
- Discounts not applicable to certain brand name Vision Materials for which the manufacturer imposes a no-discount practice.
- Benefits may not be combined with any discount or promotional offering unless otherwise noted in an offer.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

When you visit a network doctor, you do not complete any paperwork or claim forms. Aetna Vision doctors verify your eligibility, plan coverage and obtain authorization from Aetna Vision.

If you decide not to see an Aetna Vision doctor, you are required to pay the provider in full at the time of your appointment and submit a claim for reimbursement up to the amount allowed by the plan.

You may obtain an out-of-network claim form for reimbursement by visiting our website, www.aetnafeds.com or calling our customer service at 1-855-347-6899. Please keep a copy of the information and mail the originals to:

Aetna Vision
Attn: OON Claims
PO Box 8504
Mason, OH 45040-7111

Deadline for Filing Your Claim

Out-of-network claims must be submitted to Aetna Vision within 15 months of the date of service for reimbursement.

Disputed Claims Process

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

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

a) Write to us within 15 months from the date of our decision; and

b) Send your request to us at: Aetna Vision, Attention: Appeal Resolution Team, PO Box 14463, Lexington, KY 40512; and

Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and include copies of documents that support your claim, and explanation of benefits (EOB) forms. This is your first level appeal.

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

a) Pay the claim (or, if applicable, arrange for the vision provider to give you the care); or

b) Write to you and maintain our denial – go to step 3; or

c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

3. If the dispute is not resolved through the reconsideration process, and the reason for the denial was based on medical necessity or for experimental or investigational reasons, you have the right to file a second level appeal. That appeal must be submitted within 60 days following the receipt of our first level denial.

4. If you do not agree with our final decision, and the amount of your claim is more than

$300 and the plan denied your claim because it did not consider the treatment a medical necessity, you may request an independent third party, mutually agreed upon by us and OPM, review the decision. You have 30 days from the date you received our final decision to request a third party review.

The decision of the independent third party is binding and is the final review of your claim. This decision is not subject to judicial review.

Section 9 Definitions of Terms We Use in This Brochure

Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Enrollee	The Federal employee, annuitant, or TRICARE-eligible individual enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Plan Allowance	The maximum benefit payment for services received. Please refer to Section 4, Your Cost for Covered Services, for the maximum benefit payment for services received in limited access areas or out-of-network and Section 6, International Services and Supplies, for services received outside the United States or Puerto Rico.
Pre-Authorization	This is the procedure used by the plan to pre-approve services and the amount that the plan will cover.
Sponsor	Generally, a sponsor means the individual who is eligible for medical or dental benefits under 10 U.S.C. chapter 55 based on their direct affiliation with the uniformed services (including military members of the National Guard and Reserves).
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	Aetna Vision
You	Enrollee or eligible family member.

Stop Healthcare Fraud!

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, plan, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your explanation of benefits (EOBs) statements, which is available online at www.aetnavision.com.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, **call us at 1-855-347-6899 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.

Summary of Benefits

- **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 number 1-877-889-5680.
- NOTE: Prescription Eyewear – Choose eyeglass lenses or contact lenses every calendar year. You cannot use both benefits within the same calendar year.

	You Pay	
High Option Benefits	**In-Network**	**Out-of-Network**
Eye Exam –a comprehensive exam that focuses on your eyes and overall wellness.	Nothing	Reimbursed up to $40
Lenses – Standard Plastic single vision, lined bifocal, lined trifocal and lenticular lenses. NOTE: **Prescription Eyewear** - Choose eyeglass lenses or contact lenses every calendar year. You cannot use both benefits within the same calendar year.	Nothing	**Reimbursed up to:** Single vision $40 Lined bifocal $60 Lined trifocal $80 Lenticular $80
Lens options, including: Standard Polycarbonate lenses (shatter resistant)	Nothing	Reimbursed up to $5
Lens options, including: Standard Scratch resistant coating	Nothing	Reimbursed up to $5
Lens options, including: Standard Anti-reflective coating	$20	Reimbursed up to $5
• Premium Anti-reflective coatings tier 1	$32	Reimbursed up to $5
• Premium Anti-reflective coatings tier 2	$43	Reimbursed up to $5
• Premium Anti-reflective coatings tier 3	80% of retail price	Reimbursed up to $5
Lens options, including: Tints	Nothing	Reimbursed up to $5
Lens options, including: UV protection	Nothing	Reimbursed up to $5
Lens options, including: Photochromic Lenses - lenses are clear indoors and darken outside	$75 fixed discount*	Not covered
Lens options, including: Standard progressive lenses	Nothing	Reimbursed up to $60
Lens options, including: Premium progressive lenses Tiers 1-3	$40-$65	Reimbursed up to $60
Lens options, including: Other premium progressive lenses	80% of charge less $120 allowance + $20 copay	Reimbursed up to $60
Conventional contact lenses – **NOTE**: **Contact Lenses,** Choose eyeglass lenses or contact lenses every calendar year. You cannot use both benefits within the same calendar year.	Any amount over $170 plan allowance after a 15% discount	Reimbursed up to $136

High Option Benefits - continued on next page

	You Pay	
High Option Benefits (cont.)	**In-Network**	**Out-of-Network**
Disposable contact lenses	Any amount over $170 plan allowance	Reimbursed up to $136
Medically necessary contact lenses	Nothing	Reimbursed up to $210
Frame - Once every calendar year. Any frame available at the provider location	Nothing for frames up to the $300 plan allowance Frame Greater than $300: pay any amount after a 20% discount	Reimbursed up to $150
Extra Discounts and Savings Prescription glasses • Minimum 20% savings on all non-covered lens options • Up to 40% discount off additional pairs of prescription glasses and sunglasses; Up to 20% off non-prescription sunglasses Retinal imaging (also known as fundus photography) - When available at a participating provider's office, members will pay no more than $39 for this service. Laser vision correction Members will receive a discount of 15% off retail or 5% off promotional prices at providers in the US Laser network. Or, members can save $800 and get a free LASIK exam at featured LasikPlus Vision Centers for a limited time. The LASIK discount is only available from U.S. Laser Network by calling 1-800-422-6600. Replacement Contact Lens Program: Receive significant savings on replacement contact lens after your plan allowance has been exhausted by ordering online. Visit www.aetnavision.com for details.	Available	Not available
Standard Option Benefits	**In-Network**	**Out-of-Network**
Eye Exam - a comprehensive exam that focuses on your eyes and overall wellness.	Nothing	Reimbursed up to $40
Lenses - Standard Plastic single vision, lined bifocal, lined trifocal and lenticular lenses NOTE: **Prescription Eyewear** - Choose eyeglass lenses or contact lenses every calendar year. You cannot use both benefits within the same calendar year.	$10	**Reimbursed up to:** Single Vision - $40 Lined bifocal - $60 Lined trifocal - $80 Lenticular - $80

Standard Option Benefits - continued on next page

	You Pay	
Standard Option Benefits (cont.)	**In-Network**	**Out-of-Network**
Lens options, including: Standard Polycarbonate lenses (shatter-resistant)	Nothing	Reimbursed up to $5
Lens options, including: Standard Scratch-resistant coating	Nothing	Reimbursed up to $5
Lens options, including: Standard progressive lenses	$75	Reimbursed up to $60
Lens options, including: Premium progressive lenses Tiers 1-3	$95-$120	Reimbursed up to $60
Lens options, including: Other premium progressive lenses	80% of charge less $120 allowance + $75 copay	Reimbursed up to $60
Lens options, including: Standard Anti-reflective coating	$45 fixed discount*	Not covered
• Premium Anti-reflective coatings tier 1	$57 fixed discount *	Not covered
• Premium Anti-reflective coatings tier 2	$68 fixed discount *	Not covered
• Premium Anti-reflective coatings tier 3	80% of retail price	Not covered
Lens options, including: Photochromic Lenses - lenses are clear indoors and darken outside	$75 fixed discount*	Not covered
Conventional contact lenses – **NOTE: Contact Lenses**, Choose eyeglass lenses or contact lenses every calendar year. You cannot use both benefits within the same calendar year.	Any amount over $150 plan allowance after a 15% discount	Reimbursed up to $120
Disposable contact lenses	Any amount over $150 plan allowance	Reimbursed up to $120
Medically necessary contact lenses	Nothing	Reimbursed up to $210
Frame - Once every calendar year. Any frame available at the provider location	Nothing for frames up to the $160 plan allowance Frame Greater than $160: pay any amount after a 20% discount	Reimbursed up to $80
Extra Discounts and Savings Prescription glasses • Minimum 20% savings on all non-covered lens options • Up to 40% discount off additional pairs of prescription glasses and sunglasses; Up to 20% off non-prescription sunglasses Retinal imaging (also known as fundus photography) - When available at a participating provider's office, members will pay no more than $39 for this service.	Available	Not Available

Standard Option Benefits - continued on next page

	You Pay	
Standard Option Benefits (cont.)	**In-Network**	**Out-of-Network**
Laser vision correction Members will receive a discount of 15% off retail or 5% off promotional prices at providers in the US Laser network. Or, members can save $800 and get a free LASIK exam at featured LasikPlus Vision Centers for a limited time. The LASIK discount is only available from U.S. Laser Network by calling 1-800-422-6600. Replacement Contact Lens Program: Receive significant savings on replacement contact lens after your plan allowance has been exhausted by ordering online. Visit www.aetnavision.com for details.	Available	Not Available

*The amount shown is the negotiated discounted price you will pay the provider. Discounts may not be available in all states at all in-network providers. To see a list of providers who do honor discounts, go to www.aetnavision.com, select Find a Provider, and if you see "May not accept all additional plan discounts" you should contact the provider to confirm.

Notes

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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**
$5.68	**$11.34**	**$17.02**	**$12.31**	**$24.57**	**$36.88**

Standard - Bi-Weekly			Standard - Monthly		
Self Only	**Self Plus One**	**Self and Family**	**Self Only**	**Self Plus One**	**Self and Family**
$3.17	**$6.33**	**$9.50**	**$6.87**	**$13.72**	**$20.58**