Delta Dental's Federal Employees Dental Program®

deltadentalfeds.org

2017

A Nationwide Dental PPO Plan

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

Enrollment Options for this Plan:

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

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

FEDVIP
Federal Employees
Dental And Vision Insurance Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
www.opm.gov/healthcare-insurance

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The Act directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants, and their eligible family members. 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.

This brochure describes the benefits of Delta Dental's Federal Employees Dental Program under Delta Dental of California contract OPM01-FEDVIP-01AP-3 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

Delta Dental of California
Federal Employees Dental Program
PO Box 537008
Sacramento, CA 95853-7008
855-410-3255
deltadentalfeds.org

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

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits, if they are also listed on the coverage. You and your family members do not have a right to benefits that were available before January 1, 2017, unless those benefits are also shown in this brochure.

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

Delta Dental maintains the network of providers available to enrollees in the Federal Employees Dental Program. You may view the most current network provider directory on our website at deltadentalfeds.org, or you may contact us at 855-410-3255 (TDD 866-847-1264) to request a list of participating providers in your area. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not for a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in Delta Dental's network for the Federal Employees Dental Program. You cannot change plans because of changes to the provider network. If your provider is not currently participating in the provider network, you may nominate him or her to join at http://www.deltadentalca.org/enrollee/forms/Nominatedentist.asp?DPO. Nomination forms are available on our website, or call us and we will have a form sent to you. Please note that Delta Dental offers various dental plans in the U.S. and not all Delta Dental network dentists are consider "in-network" for the Federal Employees Dental Program.

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.

Delta Dental's Federal Employees Dental Program and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program.

We want you to know that protecting the confidentiality of your individually identifiable health information is of the utmost importance to us. To review full details about our privacy practices, our legal duties, and your rights, please visit our website at deltadentalfeds.org. If you do not have access to the Internet or would like further information, please contact us by calling 855-410-3255.

Discrimination is Against the Law

Delta Dental's Federal Employees Dental Program complies with all applicable Federal civil rights laws, to include both Title VII and Section 1557 of the ACA. Pursuant to Section 1557, Delta Dental's Federal Employees Dental Program does not exclude people or treat them differently on the basis of race, color, national origin, age, disability, or sex (including pregnancy and gender identity).

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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. Visit www.opm.gov/healthcare-insurance/dental-vision/ for more information.
Enroll Through BENEFEDS	You enroll online at www.BENEFEDS.com. Please see Section 2 Enrollment for more information.
Dual Enrollment	If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2016 Open Season, your coverage will begin on January 1, 2017. Premium deductions will start with the first full pay period beginning on/after January 1, 2017. 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.
Annual Enrollment Opportunity	Each year, an Open Season will be held, during which you may enroll or change your dental and/or vision plan enrollment. This year, Open Season runs from November 14, 2016 through midnight EST December 12, 2016. You do not need to re-enroll each Open Season unless you wish to change plans or plan options; your coverage will continue from the previous year. In addition to the annual Open Season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2 Enrollment for more information.
Continued Group Coverage After Retirement	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may also be able to continue enrollment after your death. Please see Section 1 Eligibility for more information.
Waiting Period	The only waiting period is for orthodontic services. To meet this requirement, the person receiving the services must be enrolled in this plan for the entire waiting period of 12 months.

Section 1 Eligibility

Federal Employees

If you are a Federal or U.S. Postal Service employee, you are eligible to enroll in FEDVIP, if you are eligible for the Federal Employees Health Benefits (FEHB) Program or the Health Insurance Marketplace (Exchange) and your position is not excluded by law or regulation, you are eligible to enroll in FEDVIP. Enrollment in the FEHB Program or a Health Insurance Marketplace (Exchange) plan is not required.

Federal Annuitants

You are eligible to enroll if you:

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

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

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

Survivor Annuitants

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

Compensationers

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

Family Members

Eligible family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

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

Not Eligible

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

- Deferred annuitants
- Former spouses of employees or annuitants
- FEHB Temporary Continuation of Coverage (TCC) enrollees
- Anyone receiving an insurable interest annuity who is not also an eligible family member

Section 2 Enrollment

Enroll Through BENEFEDS

You must use BENEFEDS to enroll or change enrollment in a FEDVIP plan. BENEFEDS is a secure enrollment website (www.BENEFEDS.com) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not want to change plans, **your enrollment will continue automatically. Please Note: Your plan's premiums may change for 2017.**

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.

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

Self and Family: A Self and Family enrollment covers you as the 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) can not 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 or annuitant, you may enroll in a dental and/or vision plan during the November 14, 2016 through midnight EST December 1, 2016 Open Season. Coverage is effective January 1, 2017.

During future annual Open Seasons, you may enroll in a plan, change or cancel your dental 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.

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	From Not Enrolled to Enrolled	Increase Enrollment Type	Decrease Enrollment Type	Cancel	Change from One Plan to Another
Marriage	Yes	Yes	No	No	Yes
Acquiring an eligible family member (non-spouse)	No	Yes	No	No	No
Losing a covered family member	No	No	Yes	No	No
Losing other dental/vision coverage (eligible or covered person)	Yes	Yes	No	No	No
Moving out of regional plan's service area	No	No	No	No	Yes
Going on active military duty, non-paystatus (enrollee or spouse)	No	No	No	Yes	No
Returning to pay status from active military duty (enrollee or spouse)	Yes	No	No	No	No
Returning to pay status from Leave without pay	**Yes (if enrollment cancelled during LWOP)**	No	No	No	**Yes (if enrollment cancelled during LWOP)**
Annuity/ compensation restored	Yes	Yes	Yes	No	No
Transferring to an eligible position*	No	No	No	Yes	No

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

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

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

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

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

Canceling an enrollment

You may cancel your enrollment only during the annual Open Season. An eligible family member's coverage also ends upon the effective date of the cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the Open Season effective date.

When Coverage Stops

Coverage ends when you:

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

Coverage for a family member ends when:

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

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.

If you have an HCFSA or LEX HCFSA FSAFEDS account and you haven't exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over up to $500 of unspent funds into another health care or limited expense account for the subsequent year. To be eligible for carryover, you must be employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31. You must also actively reenroll in a health care or limited expense account during the NEXT Open Season to be carryover eligible. Your reenrollment must be for at least the minimum of $100. If you do not reenroll, or if you are not employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st, your funds will not be carried over.

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

For a health care or limited expense account, each participant must contribute a minimum of $100 to a maximum of $2,550.

Current FSAFEDS participants must re-enroll to participate next year. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-866-353-8058.

If you are enrolled in an FSAFEDS HCFSA, you can take advantage of the Paperless Reimbursement option, which allows you to be reimbursed from your HCFSA without submitting an FSAFEDS claim. When Delta Dental receives a Federal Employees Dental Program claim for payment, we forward information about your out-of-pocket expenses (such as copayment and deductible amounts) to FSAFEDS for processing. FSAFEDS then reimburses you for your eligible out-of-pocket costs without the need for a claim form or receipt. Reimbursement is made directly to your bank from your HCFSA ccount via electronic funds transfer. You may need to file a paper claim to FSAFEDS in certain situations. Visit www.FSAFEDS.com for more information.

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you can use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB and FEDVIP plans. You will be required to submit your claim on behalf of Delta Dental's Federal Employees Dental Program to the FSAFEDS Health Care Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA).

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation

When you enroll for the first time, you will receive a welcome letter along with an identification card ("ID Card"). It is important to bring your FEDVIP and FEHB ID cards to every dental appointment. Because most FEHB plans offer some level of dental benefits separate from your FEDVIP coverage, presenting both ID cards can ensure that you receive the maximum allowable benefit under each program along with accurate and timely claims processing.

If you require a replacement ID card, you will be able to print your ID card through the Consumer Toolkit® at deltadentalfeds.org. An ID card is neither a guarantee of benefits nor is it required in order for you to obtain dental services. Your provider may call 855-410-3255 to confirm your enrollment in the plan and the benefits available to you.

If you were enrolled in Delta Dental's Federal Employees Dental Program in 2016 and continue coverage for 2017, Delta Dental will send you a confirmation letter only. The Plan Brochure can be viewed and printed from our website at deltadentalfeds.org.

Where You Get Covered Care

Plan benefits are available, subject to plan provisions, from any licensed dentist in the 50 United States, the District of Columbia and Puerto Rico as well as overseas.

Plan Providers

The provider network for Delta Dental's Federal Employees Dental Program consists of independently credentialed and contracted providers. IMPORTANT: Note there are different dentist networks for other Delta Dental plans—so be sure to use the Dentist Search function at deltadentalfeds.org to find a dentist who participates in the network for Delta Dental's Federal Employees Dental Program. Contact your dentist to verify he/she is participating in Delta Dental's Federal Employees Dental Program.You may also contact Customer Service at 855-410-3255 for a list of Federal Employees Dental Program network providers near you.

In-Network

Delta Dental's Federal Employees Dental Program network dentists are available in the 50 U.S. states, the District of Columbia and Puerto Rico. (Note: Delta Dental Premier® dentists are in-network for South Dakota and Wyoming ***only***. Delta Dental PPO℠ dentists are considered in-network for all other states.) Our list of participating network dentists is updated daily. When you make your appointment, please advise the dental office that you are enrolled in the Federal Employees Dental and Vision Insurance Program (FEDVIP) and wish to use your in-network benefits; be sure to confirm that the dentist is a participating network provider for Delta Dental's Federal Employees Dental Program.

Delta Dental's Federal Employees Dental Program network does not require an enrollee to select a primary care provider. When you use a Delta Dental Federal Employees Dental Program network provider, you are responsible only for billable charges up to our negotiated plan allowance per procedure. You are not responsible for treatment service charges in excess of the in-network negotiated per-procedure maximum unless you consent in writing to additional treatment charges.

Out-of-Network

You may obtain care from any licensed dentist. If the dentist is not part of our network, benefits will be considered out-of-network. When you see a dentist who is outside of Delta Dental's participating network for the Federal Employees Dental Program, you will have a lower annual maximum benefit and we pay for services based on an out-of-network plan allowance. You are responsible for any difference between the plan payment and the amount submitted/approved.

Emergency Services

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

	All expenses for emergency services are payable as any other expense and are subject to plan limitations such as deductibles, frequencies and maximums. If you use an out-of-network provider for emergency services, benefits will be paid under the out-of-network plan provisions. You are responsible for the difference between the plan payment and the amount submitted/approved.
Plan Allowance	The plan allowance is the amount we allow for a specific procedure. When you use a participating Delta Dental Federal Employees Dental Program provider, your out-of-pocket cost is limited to the difference between the plan allowance and our payment. When you use an out-of-network dentist, you are responsible for the difference between the plan allowance and our payment plus the difference up to the submitted/approved charges.
Precertification/ Predetermination Notice	You and your provider may request us to predetermine benefits for dental procedures that your dentist has planned. This is especially recommended for more complex and/or major procedures. We will provide both you and your dentist with a non-binding, written Pre-treatment Estimate indicating if the procedures are covered and, if so, an estimate of what we will pay for those specific procedures. When the treatment is complete, the provider will fill in the date(s) of service on the Pre-treatment Estimate,, sign and date the notice, and return it to Delta Dental at the address provided for claims submission (see Section 9 Claims Filing and Disputed Clams Processes). Pre-treatment Estimates submitted for payment will be processed in accordance with Delta Dental's claims processing policies. The final determination of eligibility, maximums, program benefits, limitations and allowable fees will be made by Delta Dental when the Pre-treatment Estimate is processed for payment.
Alternate Benefit	If more than one service or procedure can be used to treat the dental condition, Delta Dental reserves the right to authorize an alternate, less costly covered service as deemed by a dental professional to be appropriate and to meet broadly accepted national standards of dental practice.
Dental Review	Some dental services submitted on a claim may be reviewed if deemed appropriate. Your provider should submit radiographic images with crowns and periodontal charting with periodontal surgeries. There may be situations resulting from the dental review in which an alternate benefit is recommended. For more extensive and costly services, we recommend that a Pre-Treatment Estimate request be submitted so you have an estimate of your coverage before the services are rendered.
First Payor	It is important to know that, per FEDVIP requirements, the FEHB plan will always be the first payor when you are also covered under Delta Dental's Federal Employees Dental Program. Therefore, it is important to provide your dental office with both your FEHB ID card and your Delta Dental Federal Employees Dental Program enrollment card at each appointment. When you visit a provider who participates with both, your FEHB plan and your FEDVIP plan, the FEHB 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 and FEDVIP benefit payments and the FEDVIP plan allowance. We are responsible for facilitating the process with the primary FEHB payor.
Coordination of Benefits	We will coordinate benefit payments with the payment of benefits under other group health benefits coverage (non-FEHB) you may have and the payment of dental/vision costs under no-fault insurance that pays benefits without regard to fault. If you are covered under a non-FEHB plan, Delta Dental’s Federal Employees Dental Program Dental benefits will be coordinated using traditional COB provisions for determining payment.

If your other dental coverage is part of your FEHB plan, it is important to note that by law, your FEHB plan must pay first. Your dentist must submit your claim to your FEHB carrier first and then to Delta Dental. It is your responsibility to let the dentist know if you have both FEHB and FEDVIP coverage so the claim is submitted and processed correctly.

Right of Recovery

If the amount we pay is more than we should have paid under the First Payor provision or when benefits are coordinated, we may recover the excess from one or more of:

- the person we have paid;
- Insurance companies; or
- other organizations.

However, the member will never be held responsible for a greater out-of-pocket amount than he/she would have been responsible for had there been no overpayment.

Rating Areas

Your rates are determined based on where you live. This is called a rating area. If you move, you must update your address through BENEFEDS at www.BENEFEDS.com or by phone at 877-888-3337. Your rates might change because of the move.

Limited Access Area

If you live in an area with insufficient access (based on contractual standards) to a Delta Dental Federal Employees Dental Program network provider and you receive covered services from an out-of-network dentist, we will pay the same benefit level as if you used the services of an in-network dentist. Your responsibility is limited to any difference between the amount billed and our payment.

Section 4 Your Cost For Covered Services

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

Deductible

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

	In-Network High Option	**In-Network Standard Option**	**Out-of-Network High Option**	**Out-of-Network Standard Option**
Class A	$0	$0	$0	$0
Class B	$0	$0	$50	$75
Class C	$0	$0	$50	$75
Orthodontics	$0	$0	$0	$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.

	In-Network High Option	**In-Network Standard Option**	**Out-of-Network High Option**	**Out-of-Network Standard Option**
Class A	0%	0%	10%	40%
Class B	30%	45%	40%	60%
Class C	50%	65%	60%	80%
Orthodontics	50%	50%	50%	50%

Annual Benefit Maximum

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

	In-Network High Option	**In-Network Standard Option**	**Out-of-Network High Option**	**Out-of-Network Standard Option**
Maximum Annual Benefits	$4,000	$1,500	$3,000	$600

Lifetime Benefit Maximum

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

	In-Network High Option	In-Network Standard Option	Out-of-Network High Option	Out-of-Network Standard Option
Lifetime Orthodontic Maximum	$2,000	$2,000	$2,000	$1,000

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 services rendered by an out-of-network provider based on an out-of-network plan allowance.

Plan Allowance

The plan allowance is the amount we allow for a specific procedure. When you use a participating provider, your out-of-pocket cost is limited to the difference between the plan allowance and our payment. When you use an out-of-network provider, you are responsible for the difference between our payment and the submitted/approved amount.

Calendar Year

The calendar year refers to the plan year, which is defined as January 1, 2017 to December 31, 2017.

Tooth Missing but Not Replaced Rule

The installation of complete or partial removable dentures, fixed partial dentures (bridges), implants and other prosthodontic services will be covered when replacing or repairing a pre-existing, failed prosthodontic appliance/device that was in existence prior to your coverage effective date under the Delta Dental Federal Employees Dental Program. Initial prosthodontic services to replace natural teeth that were missing prior to your Delta Dental Federal Employees Dental Program date of coverage are not covered.

Section 5 Dental Services and Supplies Class A Basic

Important things you should keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this plan brochure and are payable only when determined to be necessary for the prevention, diagnosis, care, or treatment of a covered condition and if they are determined to meet generally accepted dental protocols.
- The calendar year deductible is $0 under both the High and Standard options when services are rendered by an in-network provider.
- If an out-of-network provider renders the services, there is a $50.00 deductible per person per calendar year for the High Option and a $75.00 deductible per person per calendar year for the Standard Option. Each enrolled covered person must satisfy his/her own deductible; there is no family deductible in either option.
- The annual benefit maximum in the High Option is $4,000 for non-orthodontic services when the services are rendered by an in-network provider and $3,000 when services are rendered by an out-of-network provider. The annual benefit maximum in the Standard Option is $1,500 when services are rendered by an in-network provider and $600 when services are rendered by an out-of-network provider.
- Under no circumstances will Delta Dental's Federal Employees Dental Program allow more than $4,000 in combined benefits under the High Option in any plan year or more than $1,500 in combined benefits under the Standard Option in any plan year.
- Any dental service or treatment not listed as a covered service is not eligible for benefits. Also see Section 7, General Exclusions – Things We Do Not Cover, for a list of exclusions and limitations.

You Pay:

- ***High Option***
  - **In-Network:** $0 for covered services as defined by the plan and subject to plan limitations and maximums.
  - **Out-of-Network:** 10% of the plan's out-of-network allowance and any difference between that allowance and the billed/approved amount.
- ***Standard Option***
  - **In-Network:** $0 for covered services as defined by the plan and subject to plan limitations and maximums.
  - **Out-of-Network:** 40% of the plan's out-of-network allowance and any difference between that allowance and the billed/approved amount.

Diagnostic Services

D0120 Periodic oral evaluation – established patient - Limited to two in 12 months
D0140 Limited oral evaluation - problem-focused – Limited to one in 12 months
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150 Comprehensive oral evaluation – new or established patient - Limited to one in 12 months
D0180 Comprehensive periodontal evaluation – new or established patient - Limited to two in 12 months
D0210 Intraoral - complete set of radiographic images – Limited to one every 48 months
D0220 Intraoral - periapical first radiographic image
D0230 Intraoral - periapical each additional radiographic image
D0240 Intraoral - occlusal radiographic image
D0250 Extraoral - 2D projection radiographic images created using a stationary radiation source, and detector
D0251 Extraoral - posterior dental radiographic image
D0270 Bitewing - single radiographic image – Limited to one in 12 months

Diagnostic Services - continued on next page

Diagnostic Services (cont.)

D0272 Bitewings - two radiographic images – Limited to one in 12 months

D0273 Bitewings - three radiographic images – Limited to one in 12 months

D0274 Bitewings - four radiographic images – Limited to one in 12 months

D0277 Vertical bitewings - 7 to 8 radiographic images – Limited to one in 12 months

D0330 Panoramic radiographic images – Limited to one every 48 months

D0425 Caries susceptibility tests

Benefit Limitations for Class A Diagnostic Services

1. Pulp vitality tests are considered integral to all services.
2. Examinations/evaluations by specialists are payable as comprehensive or periodic examinations/evaluations and are counted towards the limitation on examinations/evaluations.
3. A full-mouth series (complete series) of radiographs includes bitewings. Any additional radiographic image taken with a complete radiographic series is considered integral to the complete series.
4. If the total fee for individually listed radiographs equals or exceeds the fee for a complete series, these radiographs are paid as a complete series and are subject to the same benefit limitations.
5. Payment for more than one of any category of full-mouth radiographs within a 48-month period is the patient's responsibility.
6. A panoramic radiograph taken with any other radiographic image is considered a full-mouth series and is paid as such, and is subject to the same benefit limitation. A panoramic radiograph is not a benefit for patients under six years of age.
7. Payment for periapical radiographic images (other than as part of a complete series) is limited to four within a 12-month period except when done in conjunction with emergency services and submitted by report.
8. Payment for a bitewing survey, whether single, two, three, four or vertical radiographic image(s), including those taken as part of a complete series, is limited to one within a 12-month period.

Preventive Services

D1110 Prophylaxis - Adult – Limited to two in 12 months

D1120 Prophylaxis - Child – Limited to two in 12 months

D1206 Topical application of fluoride varnish

D1208 Topical application of fluoride - excluding varnish – Limited to two in 12 months

D1351 Sealant - per tooth - permanent molars free from caries to patients under 19 – Limited to one in 36 months

D1352 Preventive resin restoration in a moderate-to-high-caries-risk patient - permanent tooth

D1510 Space maintainer - fixed - unilateral – For dependent children under age 19

D1515 Space maintainer - fixed - bilateral – For dependent children under age 19

D1520 Space maintainer - removable - unilateral – For dependent children under age 19

D1525 Space maintainer - removable - bilateral – For dependent children under age 19

D1550 Recement or rebond space maintainer – Payable once in 12 months

D1575 Distal shoe space maintainer – fixed – unilateral – For dependent children under age 19

Preventive Services - continued on next page

Preventive Services (cont.)

Benefit Limitations for Class A Preventive Services

1. Periodontal scaling in the presence of gingival inflammation is considered to be a routine prophylaxis and is paid as such. Participating dentists may not bill the patient for any difference in fees.
2. There are no provisions for special consideration for a prophylaxis based on degree of difficulty. Scaling or polishing to remove plaque, calculus and stains from teeth is considered to be part of the prophylaxis procedure.
3. Topical fluoride applications are covered only when performed as independent procedures. Use of a prophylaxis paste containing fluoride is payable as a prophylaxis only.
4. Routine oral hygiene instructions are considered integral to a prophylaxis service.
5. The tooth number of the space to be maintained is required when requesting payment for space maintainers.
6. The fee for a stainless steel crown or band retainer is considered to be included in the total fee for the space maintainer.
7. Sealants provided on the same date of service and on the same tooth as a restoration of the occlusal surface are considered integral procedures.

D1575 Distal shoe space maintainer - fixed - unilateral - For dependent children under age 19

Additional Procedures Covered as Class A Basic Services

D9110 Palliative (emergency) treatment of dental pain - minor procedure

Class B Intermediate

Important things you should keep in mind about these benefits:

- All benefits are subject to the definitions, limitations and exclusions in this plan brochure and are payable only when determined to be necessary for minor restorative care or treatment of a covered condition and if they are determined to meet generally accepted dental protocols.
- The calendar year deductible is $0 under both the High and Standard options when services are provided by an in-network provider.
- If an out-of-network provider renders the services, there is a $50.00 deductible per person per calendar year for the High Option and a $75.00 deductible per person per year for the Standard Option. Each enrolled covered person must satisfy his/her own deductible; there is no family deductible in either option.
- The annual benefit maximum in the High Option is $4,000 for non-orthodontic services when the services are rendered by an in-network provider and $3,000 when services are rendered by an out-of-network provider. The annual benefit maximum in the Standard Option is $1,500 for non-orthodontic services when services are rendered by an in-network provider and $600 when services are rendered by an out-of-network provider.
- Under no circumstance will Delta Dental's Federal Employees Dental Program allow more than $4,000 in combined benefits under the High Option in any plan year or more than $1,500 in combined benefits under the Standard Option in any plan year.
- Any dental service or treatment not listed as a covered service is not eligible for benefits. Also see Section 7, General Exclusions – Things We Do Not Cover, for a list of exclusions and limitations.

You Pay:

- ***High Option***
  - **In-Network:** 30% of the network allowance for covered services as defined by the plan and subject to plan limitations and maximums.
  - **Out-of-Network:** 40% of the plan's out-of-network allowance along with a $50 deductible and any difference between that allowance and the billed/approved amount.
- ***Standard Option***
  - **In-Network:** 45% of the network allowance for covered services as defined by the plan subject to plan limitations and maximums.
  - **Out-of-Network:** 60% of the plan's out-of-network allowance along with a $75 deductible and any difference between that allowance and the billed/approved amount.

Minor Restorative Services

D2140 Amalgam – one surface, primary or permanent
D2150 Amalgam – two surfaces, primary or permanent
D2160 Amalgam – three surfaces, primary or permanent
D2161 Amalgam – four or more surfaces, primary or permanent
D2330 Resin-based composite – one surface, anterior
D2331 Resin-based composite – two surfaces, anterior
D2332 Resin-based composite – three surfaces, anterior
D2335 Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2391 Resin-based composite – one surface, posterior
D2392 Resin-based composite – two surfaces, posterior

Minor Restorative Services - continued on next page

Minor Restorative Services (cont.)

D2393 Resin-based composite – three surfaces, posterior

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

D2910 Recement or rebond inlay, onlay, veneer or partial coverage restorations

D2920 Recement or rebond crown

D2930 Prefabricated stainless steel crown – primary tooth - One per patient, per tooth, per lifetime

D2931 Prefabricated stainless steel crown – permanent tooth - One per patient, per tooth, per lifetime

D2951 Pin retention – per tooth, in addition to restoration

Benefit Limitations for Class B Minor Restorative Services

1. Pin retention is covered only when reported in conjunction with an eligible restoration.
2. Preventive resin restorations or other restorations that do not extend into the dentin are considered sealants for purposes of determining benefits.
3. Repair or replacement of restorations by the same dentist/dental office and involving the same tooth surfaces performed within 24 months of the original restoration are considered integral procedures, and a separate fee is not chargeable to the member by a participating dentist regardless of the number of combinations of restorations placed. However, payment may be allowed if the repair or replacement is due to fracture of the tooth or the restoration involves the occlusal surface of a posterior tooth or the lingual surface of an anterior tooth and is placed following root canal therapy.
4. The payment for restorations includes all related services including but not limited to etching, bases, liners, dentinal adhesives, local anesthesia, polishing caries removal, preparation of gingival tissue, occlusal/contact adjustments and detection agents.
5. Restorations are covered benefits only when necessary to replace tooth structure loss due to fracture or decay.
6. Prefabricated stainless steel crowns (D2930, D2931) are covered only on primary teeth, permanent teeth, or when placed as a result of accidental injury.
7. Payment for a resin restoration will be made when a laboratory-fabricated porcelain or resin veneer is used to restore any teeth due to tooth fracture or caries.

Endodontic Services

D3110 Pulp cap - direct (excluding final restoration)

D3120 Pulp cap - indirect (excluding final restoration) - Payable once per tooth

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp cornoal to the deninocemental junction and application of medicament - Payable once per tooth on primary teeth only

D3221 Pulpal debridement, primary and permanent teeth

D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development, per tooth, per lifetime

D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) - For dependent children to age 6

D3240 Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) - For dependent children to age 11 and limited to once per tooth per lifetime

Benefit Limitations for Class B Endodontic Services

1. Pulpotomies are considered integral when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
2. Pulpotomies performed on permanent teeth are considered integral to root canal therapy and are not reimbursable if root canal therapy is not and will not be provided on the same tooth.
3. For reporting and benefit purposes, the completion date for endodontic therapy is the date the tooth is sealed.
4. An indirect pulp cap is payable only when a near exposure of the pulp is evident and when the final restoration is not completed for at least 60 days.
5. Payment for gross pulpal debridement is limited to the relief of pain prior to conventional root canal therapy and when performed by a dentist not completing the endodontic therapy.

Periodontic Services

D4341 Periodontal scaling and root planing – four or more teeth per quadrant - Payable once per quadrant in 24 months

D4342 Periodontal scaling and root planing – one to three teeth, per quadrant - Payable once per quadrant in 24 months

D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation – Limited to four in 12 months combined with adult prophylaxis and periodontal maintenance

D4910 Periodontal maintenance – Limited to four in 12 months combined with D1110 and D4346

D7921 Collection and application of autologous blood concentrate product - Limited to one in 36 months

Benefit Limitations for Class B Periodontic Services

1. Documentation of the need for periodontal treatment includes periodontal pocket charting, case type, prognosis, amount of existing attached gingiva, etc. Periodontal pocket charting should indicate the area/quadrants/teeth involved and is required for most procedures.
2. Surgical periodontal procedures or scaling and root planing in the same area of the mouth within 24 months of a gingival flap procedure are not covered.
3. A routine prophylaxis is considered integral when performed in conjunction with or as a finishing procedure to periodontal scaling and root planing, periodontal maintenance, gingivectomy or gingivoplasty, gingival flap procedure or osseous surgery.
4. A combination of up to four D4910 (periodontal maintenance procedures) or D4346 (scaling in the presence of generalized moderate or sever gingival inflammation) or D1110 (adult prophylaxis) may be paid within a 12-consecutive-month period. Note: Adult prophylaxis is limited to two in 12 months (refer to Preventive Services section).
5. Periodontal maintenance is only covered when performed following active periodontal treatment.
6. An oral evaluation reported in addition to periodontal maintenance will be processed as a separate procedure subject to the policies and limitations applicable to oral evaluation.

Prosthodontic Services

D5410 Adjust complete denture – maxillary

D5411 Adjust complete denture – mandibular

D5421 Adjust partial denture – maxillary

D5422 Adjust partial denture – mandibular

D5510 Repair broken complete denture base

D5520 Replace missing or broken teeth – complete denture (each tooth)

D5610 Repair resin denture base

D5620 Repair cast framework

D5630 Repair or replace broken clasp - per tooth

D5640 Replace broken teeth – per tooth

D5650 Add tooth to existing partial denture

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 – Limited to once in 36 months

D5711 Rebase complete mandibular denture – Limited to once in 36 months

D5720 Rebase maxillary partial denture – Limited to once in 36 months

D5721 Rebase mandibular partial denture – Limited to once in 36 months

D5730 Reline complete maxillary denture (chairside) – Limited to once in 36 months

D5731 Reline complete mandibular denture (chairside) – Limited to once in 36 months

D5740 Reline maxillary partial denture (chairside) – Limited to once in 36 months

D5741 Reline mandibular partial denture (chairside) – Limited to once in 36 months

D5750 Reline complete maxillary denture (laboratory) – Limited to once in 36 months

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)

D5751 Reline complete mandibular denture (laboratory) – Limited to once in 36 months

D5760 Reline maxillary partial denture (laboratory) – Limited to once in 36 months

D5761 Reline mandibular partial denture (laboratory) – Limited to once in 36 months

D5850 Tissue conditioning, maxillary

D5851 Tissue conditioning, mandibular

D6930 Recement or rebond fixed partial denture

D6980 Fixed partial denture repair necessitated by restorative material failure

Benefit Limitations for Class B Prosthodontic Services

1. For reporting and benefit purposes, the completion date for crowns and fixed partial dentures is the cementation date. The completion date is the insertion date for removable prosthodontic appliances. For immediate dentures, however, the provider who fabricated the dentures may be reimbursed for the dentures after insertion if another provider, typically an oral surgeon, inserted the dentures.
2. The fee for diagnostic casts (study models) fabricated in conjunction with prosthetic and restorative procedures is included in the fee for these procedures. A separate fee is not chargeable to the member by a participating dentist.
3. Tissue conditioning is considered integral when performed on the same day as the delivery of a denture or a reline/rebase.
4. Recementation of crowns, fixed partial dentures, inlays, onlays, or cast posts within six months of their placement by the same dentist/dental office is considered integral to the original procedure.
5. Adjustments to or relining or rebasing of an initial or replacement denture provided within six months of the insertion of an initial or replacement denture are integral to the denture.

Oral Surgery

D7111 Extraction coronal remnants, deciduous tooth

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

D7210 Extraction of 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

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

D7280 Exposure of an unerupted tooth – Payable once per tooth per lifetime

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

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

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

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

D7471 Removal of 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

Oral Surgery - continued on next page

Oral Surgery (cont.)

Benefit Limitations for Class B Oral Surgery Services

1. Simple incision and drainage reported with root canal therapy is considered integral to the root canal therapy.
2. Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered integral to the procedure.
3. Charges for related services such as necessary wires and splints, adjustments, and follow-up visits are considered integral to the fee for reimplantation and/or stabilization (D7270).
4. The removal of impacted teeth is paid based on the anatomical position as determined from a review of x-rays. If the degree of impaction is determined to be less than the reported degree, payment will be based on the allowance for the lesser level.
5. Removal of impacted third molars in patients under age 15 and over age 30 is not covered unless specific documentation is provided that substantiates the need for removal and is approved by the contractor.
6. Routine post-operative care, including office visits, local anesthesia and suture removal, is included in the fee for the extraction.
7. The fee for root recovery is included in the fee for the extraction.
8. Incision and drainage on the same date of service with any palliative or oral surgery procedure is not payable. The procedure is considered part of those services.
9. Simple incision and drainage reported with root canal therapy is considered integral to the root canal therapy.

Class C Major

Important things you should keep in mind about these benefits:

- All benefits are subject to the definitions, limitations and exclusions in this plan brochure and are payable only when determined to be necessary for the prevention, diagnosis, care or treatment of a covered condition and if they are determined to meet generally accepted dental protocols.
- The calendar year deductible is $0 under both the High and Standard options when services are rendered by an in-network provider.
- If an out-of-network provider renders the services, there is a $50.00 deductible per person per calendar year for the High Option and a $75.00 deductible per person per calendar year for the Standard Option. Each enrolled covered person must satisfy his/her own deductible; there is no family deductible in either option.
- The annual benefit maximum in the High Option is $4,000 for non-orthodontic services when the services are rendered by an in-network provider and $3,000 when services are rendered by an out-of-network provider. The annual benefit maximum in the Standard Option is $1,500 for non-orthodontic services when services are rendered by an in-network provider and $600 when services are rendered by an out-of-network provider.
- Under no circumstances will Delta Dental's Federal Employees Dental Program allow more than $4,000 in combined benefits under the High Option in any plan year or more than $1,500 in combined benefits under the Standard Option in any plan year.
- Alternate benefits: If more than one service can be used to treat the dental condition, an alternate benefit may be authorized for a less costly service as deemed appropriate by a dental professional. Prior to receiving major services, we recommend that a precertification be submitted so you are aware of your coverage before the services are rendered.
- Any dental service or treatment not listed as a covered service is not eligible for benefits. Also see Section 7, General Exclusions – Things We Do Not Cover, for a list of exclusions and limitations.

You Pay:

- ***High Option***
  - **In-Network:** 50% of the network allowance for covered services as defined by the plan and subject to plan limitations and maximums.
  - **Out-of-Network:** 60% of the plan's out-of-network allowance along with a $50.00 deductible and any difference between that allowance and the billed/approved amount.
- ***Standard Option***
  - **In-Network:** 65% of the network allowance for covered services as defined by the plan and subject to plan limitations and maximums.
  - **Out-of-Network:** 80% of plan's out-of-network allowance along with a $75.00 deductible and any difference between that allowance and the billed/approved amount.

Major Restorative Services

D0160 Detailed and extensive oral evaluation – problem-focused, by report
D2510 Inlay – metallic – one surface
D2520 Inlay – metallic – two surfaces
D2530 Inlay – metallic – three or more surfaces
D2542 Onlay – metallic – two surfaces
D2543 Onlay – metallic – three surfaces
D2544 Onlay – metallic – four or more surfaces
D2740 Crown – porcelain/ceramic substrate

Major Restorative Services - continued on next page

Major Restorative Services (cont.)
D2750 Crown – porcelain fused to high noble metal
D2751 Crown – porcelain fused to predominantly base metal
D2752 Crown – porcelain fused to noble metal
D2780 Crown – 3/4 cast high noble metal
D2781 Crown – 3/4 cast predominantly base metal
D2782 Crown – 3/4 cast noble metal
D2783 Crown – 3/4 porcelain/ceramic
D2790 Crown – full cast high noble metal – Limited to once in five years
D2791 Crown – full cast predominantly base metal – Limited to once in five years
D2792 Crown – full cast noble metal – Limited to once in five years
D2794 Crown – titanium – Limited to once in five years
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
D2990 Resin infiltration of incipient smooth surface lesions

Benefit Limitations for Class C Major Restorative Services

1. Diagnostic casts (study models) taken in conjunction with restorative procedures are considered integral
2. Pin retention is covered only when reported in conjunction with an eligible restoration.
3. An amalgam or resin restoration reported with a pin (D2951), in addition to a crown, is considered to be a pin buildup (D2950).
4. The charge for a crown or onlay should include all charges for work related to its placement including, but not limited to, preparation of gingival tissue, tooth preparation, temporary crown, diagnostic casts (study models), impressions, try-in visits, and cementations of both temporary and permanent crowns.
5. Onlays, permanent single-crown restorations, and posts and cores for members 12 years of age or younger are excluded from coverage unless specific rationale is provided indicating the reason for such treatment (e.g., fracture, endodontic therapy, etc.) and if approved by the contractor.
6. Cast posts and cores (D2952) are processed as an alternate benefit of a prefabricated post and core. The patient is responsible for the difference between the dentist's charge for the cast post and core and the amount paid by the contractor for the prefabricated post and core.
7. Replacement of crowns, onlays, buildups, and posts and cores is covered only if the existing crown, onlay, buildup, or post and core was inserted at least five years prior to the replacement and satisfactory evidence is presented that the existing crown, onlay, buildup, or post and core is not and cannot be made serviceable. Satisfactory evidence must show that the existing crown, onlay, buildup, or post and core is not and cannot be made serviceable. The five-year service date is measured based on the actual date (day and month) of the initial services versus the first day of the initial service month.
8. Onlays, crowns, and posts and cores are payable only when necessary due to decay or tooth fracture. However, if the tooth can be adequately restored with amalgam or composite (resin) filling materials, payment will be made for that service. This payment can be applied toward the cost of the onlay, crown, or post and core.
9. When performed as an independent procedure, the placement of a post is not a covered benefit. Posts are only eligible when provided as part of a buildup for a crown and are considered integral to the buildup.
10. Services or treatment for the provision of an initial prosthodontic appliance (i.e., fixed bridge restoration, implants, removable partial or complete denture, etc.) when it replaces natural teeth extracted or missing, including congenital defects, prior to effective date of coverage are not eligible for coverage.

Endodontic Services

D3310 Endodontic therapy, anterior tooth (excluding final restoration)

D3320 Endodontic therapy, bicuspid tooth (excluding final restoration)

D3330 Endodontic therapy, molar (excluding final restoration)

D3346 Retreatment of previous root canal therapy – anterior

D3347 Retreatment of previous root canal therapy – bicuspid

D3348 Retreatment of previous root canal therapy – molar

D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) – For permanent teeth only

D3352 Apexification/recalcification – interim medication replacement – For permanent teeth only

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

D3410 Apicoectomy – anterior

D3421 Apicoectomy – bicuspid (first root)

D3425 Apicoectomy – molar (first root)

D3426 Apicoectomy (each additional root)

D3427 Periradicular surgery without apicoectomy

D3430 Retrograde filling – per root

D3450 Root amputation – per root

D3920 Hemisection (including any root removal), not including root canal therapy

Benefit Limitations for Class C Endodontic Services

1. Treatment of a root canal obstruction is considered an integral procedure.
2. For reporting and benefit purposes, the completion date for endodontic therapy is the date the tooth is sealed.
3. Placement of a final restoration following endodontic therapy is eligible as a separate procedure.
4. Retreatment of apical surgery or root canal therapy by the same dentist or group practice within 24 months is considered part of the original procedure.
5. Apexification is payable only on permanent teeth with incomplete root development or for repair of perforation. Otherwise, the fee is included in the fee for the root canal.

Periodontic Services

D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant

D4211 Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant

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 – Payable once per tooth, per lifetime

D4260 Osseous surgery (including elevation of a full thickness flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant

D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant

D4268 Surgical revision procedure, per tooth

D4270 Pedicle soft tissue graft procedure

D4273 Autogenous connective tissue graft procedure (including donor and recipient sites), first tooth, implant or edentulous tooth position in graft

Periodontic Services - continued on next page

Periodontic Services (cont.)

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 double pedicle graft, per tooth

D4277 Free soft tissue graft procedure (including recipient and donor site surgery), first tooth or edentulous tooth position in graft

D4278 Free soft tissue graft procedure (including recipient and donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth

Benefit Limitations for Class C Periodontic Services

1. Documentation of the need for periodontal treatment includes periodontal pocket charting, case type, prognosis, amount of existing attached gingiva, etc. Periodontal pocket charting should indicate the area/quadrants/teeth involved and is required for most procedures.
2. Gingivectomy or gingivoplasty, gingival flap procedures, guided tissue regeneration, soft tissue grafts, bone replacement grafts and osseous surgery provided within 24 months of the same surgical periodontal procedure in the same area of the mouth are not covered.
3. Gingivectomy or gingivoplasty performed in conjunction with the placement of crowns, onlays, crown buildups, post and cores or basic restorations are considered integral to the restoration.
4. Gingival flap procedure is considered integral when provided on the same date of service by the same dentist in the same area of the mouth as periodontal surgical procedures, endodontic procedures and oral surgery procedures.
5. A single site for reporting osseous grafts consists of one contiguous area, regardless of the number of teeth (e.g., crater) or surfaces involved. Another site on the same tooth is considered integral to the first site reported. Non-contiguous areas involving different teeth may be reported as additional sites.
6. Osseous surgery is not covered when provided within 24 months of osseous surgery in the same area of the mouth.
7. Osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service by the same dentist and in the same area of the mouth will be processed as crown lengthening.
8. Guided tissue regeneration is covered only when provided to treat Class II furcation involvement or interbony defects. It is not covered when provided to obtain root coverage, or when provided in conjunction with extractions, cyst removal or procedures involving the removal of a portion of a tooth, e.g, apicoectomy or hemisection.
9. One crown lengthening per tooth per lifetime is covered.
10. A routine prophylaxis is considered integral when performed in conjunction with or as a finishing procedure to periodontal scaling and root planing, periodontal maintenance, gingivectomy or gingivoplasty, gingival flap procedure or osseous surgery.
11. Payment for multiple periodontal surgical procedures (except soft tissue grafts, osseous grafts, and guided tissue regeneration) provided in the same area of the mouth during the same course of treatment is based on the fee for the greater surgical procedure. The lesser procedure is considered integral and its allowance is included in the allowance for the greater procedure.
12. Surgical revision procedure (D4268) is considered integral to all other periodontal procedures.
13. Subepithelial connective tissue grafts and combined connective tissue and double pedical grafts are payable at the level of free soft tissue grafts. The difference between the allowance for the soft tissue graft and the dentist's charge is the patient's responsibility.

Prosthodontic Services
D5110 Complete denture – maxillary
D5120 Complete denture – mandibular
D5130 Immediate denture – maxillary
D5140 Immediate denture – mandibular
D5211 Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5212 Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5213 Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214 Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5281 Removable unilateral partial denture – one-piece cast metal (including clasps and teeth)
D6010 Surgical placement of implant body: endosteal implant
D6013 Surgical placement of mini 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)
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061 Abutment supported porcelain fused to metal crown (noble metal)
D6062 Abutment supported cast metal crown (high noble metal)
D6063 Abutment supported cast metal crown (predominantly base metal)
D6064 Abutment supported cast metal crown (noble metal)
D6065 Implant supported porcelain/ceramic crown
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal)
D6068 Abutment supported retainer for porcelain/ceramic FPD
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070 Abutment retainer for porcelain fused to metal FPD (predominantly base metal)
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072 Abutment supported retainer for cast metal FPD (high noble metal)
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
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
D6090 Repair implant supported prosthesis, by report
D6091 Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6094 Abutment supported crown (titanium)
D6095 Repair implant abutment
D6100 Implant removal, by report
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular
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
D6194 Abutment supported retainer crown for FPD (titanium)
D6210 Pontic – cast high noble metal
D6211 Pontic – cast predominantly base metal
D6212 Pontic – cast noble metal
D6214 Pontic – titanium
D6240 Pontic – porcelain fused to high noble metal
D6241 Pontic – porcelain fused to predominantly base metal
D6242 Pontic – porcelain fused to noble metal
D6245 Pontic – porcelain/ceramic
D6548 Retainer – porcelain/ceramic for resin bonded fixed prosthesis
D6549 Resin retainer - for resin-bonded fixed prosthesis
D6600 Retainer inlay – porcelain/ceramic, two surfaces
D6601 Retainer inlay – porcelain/ceramic, three or more surfaces
D6604 Retainer inlay - indirectly fabricated predominantly base metal, two surfaces
D6605 Retainer inlay - indirectly fabricated predominantly base metal, three or more surfaces
D6608 Retainer onlay – porcelain/ceramic, two surfaces
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces
D6612 Retainer onlay - indirectly fabricated predominantly base metal, two surfaces
D6613 Retainer onlay - indirectly fabricated predominantly base metal, three or more surfaces
D6740 Retainer crown – porcelain/ceramic
D6750 Retainer crown – porcelain fused to high noble metal
D6751 Retainer crown – porcelain fused to predominantly base metal
D6752 Retainer crown – porcelain fused to noble metal
D6780 Retainer crown – 3/4 cast high noble metal
D6781 Retainer crown – 3/4 cast predominantly base metal
D6782 Retainer crown – 3/4 cast noble metal
D6783 Retainer crown – 3/4 porcelain/ceramic
D6790 Retainer crown – full cast high noble metal
D6791 Retainer crown – full cast predominantly base metal
D6792 Retainer crown – full cast noble metal
D6794 Retainer crown – titanium
D9999 Unspecified adjunctive procedure, by report

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)

Benefit Limitations for Class C Prosthodontic Services

1. Services or treatment for the provision of an initial prosthodontic appliance (i.e., fixed bridge restoration, implants, removable partial or complete denture, etc.) when it replaces natural teeth extracted or missing, including congenital defects, prior to effective date of coverage are not eligible for coverage.
2. Replacement of implants is covered only if the existing implant was placed at least five years prior to the replacement and the implant has failed.
3. Replacement of removable and/or fixed prostheses (i.e., partial and/or complete denture, fixed bridge) is covered when the existing removable and/or fixed prostheses was provided at least five years prior to the replacement. The month and year of the initial placement of the prostheses is required for coverage and claims payment. If the existing removable and/or fixed prostheses cannot be repaired, satisfactory evidence (narrative, radiographic images) is required for coverage of the replacement prostheses.
4. Replacement of implant prostheses is covered only if the existing prostheses were placed at least five years prior to the replacement and satisfactory evidence is presented that demonstrates they are not, and cannot be made, serviceable.
5. For reporting and benefit purposes, the completion date for crowns and fixed partial dentures is the cementation date. The completion date is the insertion date for removable prosthodontic appliances. For immediate dentures, however, the provider who fabricated the dentures may be reimbursed for the dentures after insertion if another provider, typically an oral surgeon, inserted the dentures.
6. The fee for diagnostic casts (study models) fabricated in conjunction with prosthetic and restorative procedures are included in the fee for these procedures. A separate fee is not chargeable to the member by a participating dentist.
7. Removable cast-base partial dentures for members under 12 years of age are excluded from coverage unless specific rationale is provided indicating the necessity for that treatment and is approved by the contractor.
8. Adjustments provided within six months of the insertion of an initial or replacement denture or implant are integral to the denture or implant.
9. The relining or rebasing of a denture is considered integral when performed within six months following the insertion of that denture.
10. Fixed partial dentures, buildups, and posts and cores for members under 16 years of age are not covered unless specific rationale is provided indicating the necessity for such treatment and is approved by the contractor.
11. Payment for a denture or an overdenture made with precious metals is based on the allowance for a conventional denture. Specialized procedures performed in conjunction with an overdenture are not covered. Any additional cost is the member's responsibility.
12. A fixed partial denture and removable partial denture are not covered in the same arch. Payment will be made for a removable partial denture to replace all missing teeth in the arch.
13. Temporary fixed partial dentures are not a covered benefit and, when done in conjunction with permanent fixed partial dentures, are considered integral to the allowance for the fixed partial dentures.
14. Implants and related prosthetics may be covered and may be reimbursed as an alternative benefit as a three-unit fixed partial denture.
15. Replacement of dentures that have been lost, stolen or misplaced is not a covered service.

Class D Orthodontic

Important things you should keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this plan brochure and are payable only when determined to be necessary for the prevention, diagnosis, care, or treatment of a covered orthodontic condition and if they are determined to meet generally accepted dental protocols.
- The calendar year deductible for orthodontic services is $0 per child under both the High and Standard options. Orthodontic services are **only** for dependent children up to age 19.
- The waiting period for orthodontic services is 12 months. To meet this requirement, the dependent child receiving orthodontic services must be covered under the same plan for the entire 12 month waiting period and continue orthodontic benefits in that same orthodontia-vested plan option.
- The lifetime maximum for orthodontic services depends on the option in which you enroll and if you chose to receive services from a network provider. If you are covered by the High Option, the lifetime maximum is $2,000 regardless of the participating status of the provider. In the Standard Option, services rendered by an in-network provider will be subject to a $2,000 lifetime maximum and services rendered by an out-of-network provider will be subject to a $1,000 lifetime maximum.
- Covered services are limited to the maximum allowable charge as determined by Delta Dental and are subject to alternative benefits, coinsurance, maximum benefit limits, waiting periods and the other limitations described in this plan brochure.
- Any dental service or treatment not listed as a covered service is not eligible for benefits. Also see Section 7, General Exclusions – Things We Do Not Cover, for a list of exclusions and limitations.

You Pay:

- ***High Option***
  - **In-Network:** 50% of the network allowance up to the lifetime maximum. You are responsible for all charges that exceed the lifetime maximum.
  - **Out-of-Network:** 50% of the plan's out-of-network allowance and any difference between that allowance and the billed amount.
- ***Standard Option***
  - **In-Network:** 50% of the network allowance up to the lifetime maximum. You are responsible for all charges that exceed the lifetime maximum.
  - **Out-of-Network:** 50% of the plan's out-of-network allowance and any difference between that allowance and the billed amount.

Orthodontic Services – Only for Dependent Children Up to Age 19

D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8050 Interceptive orthodontic treatment of the primary dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition
D8210 Removable appliance therapy
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment examination to monitor growth and development
D8670 Periodic orthodontic treatment visit

Orthodontic Services – Only for Dependent Children Up to Age 19 - continued on next page

Orthodontic Services – Only for Dependent Children Up to Age 19 (cont.)

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

D8690 Orthodontic treatment (alternative billing to a contract fee)

Benefit Limitations for Class D Orthodontic Services

1. Orthodontic treatment is available only for dependent children up to, but not including, 19 years of age. Orthodontic services for adults and for dependent children age 19 and older are not covered.
2. Payment for diagnostic services performed in conjunction with orthodontics is applied to the member's annual maximum.
3. Orthodontic consultations will be processed as comprehensive or periodic evaluations and are subject to the same time limitations.
4. Initial payment for orthodontic services will not be made until a banding date has been submitted to the contractor.
5. All retention and case-finishing procedures are integral to the total case fee. Observations and adjustments are integral to the payment for retention appliances.
6. Repair of damaged, lost or missing orthodontic appliances is not covered.
7. Recementation of an orthodontic appliance by the same dentist who placed the appliance and/or who is responsible for the ongoing care of the patient is not covered. However, recementation by a different dentist will be considered for payment as palliative emergency treatment.
8. Orthodontic treatment (alternative billing to the contract fee) will be reviewed for individual consideration with any allowance being applied to the orthodontic lifetime maximum. It is only payable for services rendered by a dentist other than the dentist rendering complete orthodontic treatment.
9. Periodic orthodontic treatment visits (as part of the contract) are considered an integral part of a complete orthodontic treatment plan and are not reimbursable as a separate service.
10. It is the dentist's and the member's responsibility to notify the carrier if orthodontic treatment is discontinued or completed sooner than anticipated.
11. When an enrollee becomes eligible for orthodontic coverage after orthodontic treatment has already begun (known as “in-progress orthodontic treatment”), the Plan’s total amount payable is prorated according to the banding date and the remaining portion of active treatment scheduled as of the patient’s date of eligibility for orthodontic coverage.

General Services

Important things you should keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this plan brochure and are payable only when determined to be necessary for the prevention, diagnosis, care, or treatment of a covered condition and if they are determined to meet generally accepted dental protocols.
- The calendar year deductible is $0 under both the High and Standard options when services are provided by an in-network provider.
- If an out-of-network provider renders services, there is a $50.00 deductible per person per calendar year for the High Option and a $75.00 deductible per person per calendar year for the Standard Option. Each enrolled covered person must satisfy his/her own deductible; there is no family deductible in either option.
- The annual benefit maximum in the High Option is $4,000 for non-orthodontic services when the services are rendered by an in-network provider and $3,000 when the services are rendered by an out-of-network provider. The annual benefit maximum in the Standard Option is $1,500 when the services are rendered by an in-network provider and $600 when the services are rendered by an out-of-network provider.
- Under no circumstance will Delta Dental's Federal Employees Dental Program allow more than $4,000 in combined benefits under the High Option in any plan year or more than $1,500 in combined benefits under the Standard Option in any plan year.
- Any dental service or treatment not listed as a covered service is not eligible for benefits. Also see Section 7, General Exclusions – Things We Do Not Cover, for a list of exclusions and limitations.

You Pay:

- ***High Option***
  - **In-Network:** 30% of the network allowance for covered services as defined by the plan and subject to plan deductibles and maximums.
  - **Out-of-Network:** 40% of the plan's out-of-network allowance along with a $50.00 deductible and any difference between that allowance and the billed/approved amount..
- ***Standard Option***
  - **In-Network:** 45% of the network allowance for covered services as defined by the plan and subject to plan deductibles and maximums.
  - **Out-of-Network:** 60% of the plan's out-of-network allowance along with a $75.00 deductible and any difference between that allowance and the billed/approved amount.

Anesthesia Services

D9223 Deep sedation/general anesthesia - each 15-minute increment

Intravenous Sedation

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

Consultations

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

Office Visits
D9440 Office visit – after regular scheduled hours
Medications
D9610 Therapeutic drug injection, by report
D9612 Therapeutic parenteral drugs, two or more administrations, different medications
Post-Surgical Services
D9930 Treatment of complications (post-surgical) unusual circumstances, by report
Miscellaneous Services
D9940 Occlusal guard, by report -- Limited to one in a 12 consecutive month period for patients 13 years of age and older
D9941 Fabrication of athletic mouth guard -- Limited to one in a 12-consecutive-month period
D9974 Internal bleaching, by report - per tooth -- Limited to once per tooth per three-year period

Benefit Limitations for General Services

1. Deep sedation/general anesthesia and intravenous conscious sedation are covered only by report when provided in connection with a covered procedure(s) and when rendered by a dentist or other professional provider licensed and approved to provide anesthesia in the state where the service is rendered.
2. Deep sedation/general anesthesia and intravenous sedation are covered only by report when determined to be medically or dentally necessary for documented/handicapped or uncontrollable patients or justifiable medical or dental conditions.
3. In order for deep sedation/general anesthesia and intravenous conscious sedation to be covered, the procedure for which it was provided must be submitted.
4. For palliative (emergency) treatment to be covered, the dentist must provide treatment to alleviate a problem or symptom that occurred suddenly and unexpectedly and that requires immediate attention. If the only service provided is to evaluate the patient and refer the patient to another dentist and/or prescribe medication, it would be considered a "Limited oral evaluation - problem-focused" (D0140).
5. Consultations are covered only when provided by a dentist other than the practitioner requesting the treatment.
6. Consultations reported for a non-covered benefit, such as temporomandibular joint dysfunction (TMJD), are not covered.
7. After-hours visits are covered only when the dentist must return to the office after regularly scheduled hours to treat the patient in an emergency situation.
8. Therapeutic drug injections are only payable in unusual circumstances, which must be documented by report. They are not benefits if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication.
9. Occlusal guards are covered for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD).
10. Internal bleaching of discolored teeth (D9974) is covered by report for endodontically treated anterior teeth. A postoperative endodontic x-ray is required for consideration if the endodontic therapy has not been submitted to the contractor for payment.

Adjunctive Services

1. Adjunctive dental care is dental care that is:
   - Medically necessary in the treatment of an otherwise covered medical (not dental) condition
   - An integral part of the treatment of such medical condition
   - Essential to the control of the primary medical condition
   - Required in preparation for, or as the result of, dental trauma which may or may not be caused by medically necessary treatment of an injury or disease (iatrogenic).
2. The Federal Employees Dental Program does not cover adjunctive care services. These are medical services that may be covered under the FEHB medical policy even when provided by a general dentist or oral surgeon. The following diagnoses or conditions may fall under this category:
   - Treatment for relief of Myofacial Pain Dysfunction Syndrome or Temporomandibular Joint Dysfunction (TMJD)
   - Orthodontic treatment for cleft lip or cleft palate, or when required in preparation for, or as a result of, trauma to teeth and supporting structures caused by medically necessary treatment of an injury or disease.
   - Procedures associated with preventive and restorative dental care when associated with radiation therapy to the head or neck unless otherwise covered as routine preventive procedures under this plan
   - Total or complete ankyloglossia
   - Intraoral abscesses which extend beyond the dental alveolus
   - Extraoral abscesses
   - Cellulitis and osteitis which is clearly exacerbating and directly affecting a medical condition currently under treatment
   - Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury
   - Prosthetic replacement of either the maxilla or mandible due to reduction of body tissues associated with traumatic injury (such as a gunshot wound) in addition to services related to treating neoplasms or iatrogenic dental trauma

Section 6 International Services and Supplies

International Claims Payment	We will pay benefits, subject to plan provisions, in an amount equal to the covered percentage for the charges incurred by you. All payments will be made in U.S. currency.
Finding an International Provider	International employees and their dependents may contact Delta Dental's international referral service for referral to dental providers outside of the continental United States, the District of Columbia and Puerto Rico or may use the dentist of their choice. Plan participants may call 312-356-5971 (collect from outside the U.S.) or 888-558-2705 (toll-free if inside the U.S.) to find a local provider in their country. International participants will receive out-of-network benefits when services are performed by an internationally located provider.
Filing International Claims	The plan participant will be responsible for paying the dentist and submitting the claims to Delta Dental's Federal Employee Dental Program for reimbursement. Mail completed claim forms to: Delta Dental of California Federal Employees Dental Program PO. Box 537007 Sacramento, CA 95853-7007
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 it is determined necessary for the prevention, diagnosis, care, or treatment of a covered condition. All out-of-network services listed in Section 5 are subject to the usual and customary maximum allowable fee charges as defined by Delta Dental's Federal Employees Dental Program. The member is responsible for all remaining charges that exceed the allowable maximum. Additionally, any dental service or treatment not listed in Section 5 as a covered service is not eligible for benefits.

We do not cover the following:

• Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;

• Services and treatment which are experimental or investigational;

• Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;

• Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;

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

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

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

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

• Telephone consultations;

• Any charges for failure to keep a scheduled appointment;

• Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;

• Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (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 x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;

• State or territorial taxes on dental services performed;

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

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

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

• Those services which are for specialized procedures and techniques;

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

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

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

• Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;

• Gold foil restorations;

• Charges for sterilizing instruments;

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

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

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

• Charges by the provider for completing dental forms;

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

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

• Cone Beam Imaging and Cone Beam MRI procedures;

• Sealants for teeth other than permanent molars;

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

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

• Orthodontic services provided to a dependent of an enrolled member who has not met the 12-month waiting period requirement;

• Repair of damaged orthodontic appliances;

• Replacement of lost or missing appliances;

• External bleaching;

• Nitrous oxide;

• Oral sedation;

• Topical medicament center;

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

• When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by Delta Dental’s Federal Employees Dental Program.

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

General Policies

All covered services are subject to the following general policies:

1. Services must be necessary to preserve functionality and maintenance of oral health to the teeth and supporting structures and must meet accepted standards of dental practice. Services determined to be unnecessary or which do not meet accepted standards of practice are not billable to the patient by a participating dentist unless the dentist notifies the patient of his/her liability prior to treatment and the patient chooses to receive the treatment. Participating dentists shall document such notification in their records.
2. The plan must provide an alternate benefit provision for benefits beyond the least expensive professionally accepted standard of care, whereby the patient pays the difference between the covered benefit and the more expensive treatment option.
3. An appeal is not available when the services are determined to be unnecessary or do not meet accepted standards of dental practice unless the dentist notifies the patient of his/her liability prior to treatment and the patient chooses to receive the treatment. This is because such services are not billable to the patient, and there would be no amount to dispute to consider an appeal.
4. Procedures should be reported using the American Dental Association's (ADA) current dental procedure codes and terminology.
5. Claims submitted for payment more than 12 months after the month in which a service is provided are not eligible for payment. A participating dentist may not bill the enrollee for services that are denied for this reason.
6. Services, including evaluations, which are routinely performed in conjunction with or as part of another service, are considered integral. Participating dentists may not bill members for services denied if they are considered integral to another service.
7. Charges for the completion of claim forms and submission of required information for determination of benefits are not payable to participating dentists by either the contractor or enrollee.
8. Local anesthesia is considered integral to the procedure(s) for which it is provided.
9. Payment for diagnostic services performed in conjunction with orthodontics may be applied to the member's annual maximum.

Class A Preventive Services

• Space maintainers for missing permanent teeth or primary anterior teeth (except primary cuspids)

• Repair of a damaged space maintainer;

Class B Minor Restorative Services

• Sedative restorations;

• Restorations performed after the placement of any type of crown or onlay on the same tooth and by the same dentist;

• Restorations placed due to abrasion, attrition, erosion, congenital or developmental malformations or to restore vertical dimension;

• Glass ionomer restorations;

Class B Periodontic Services

• Periodontal scaling and root planing provided within 24 months of periodontal scaling and root planing or periodontal surgical procedures in the same area of the mouth;

Class B Prosthodontic Services

• For reporting and benefit purposes, the completion date for crowns and fixed partial dentures is the cementation date. The completion date is the insertion date for removable prosthodontic appliances. For immediate dentures, however, the provider who fabricated the dentures may be reimbursed for the dentures after insertion if another provider, typically an Oral Surgeon, inserted the dentures.

Class B Oral Surgery Services

• Unsuccessful extractions;

• Removal of impacted third molars in patients under age 15 and over age 30 unless specific documentation is provided that substantiates the need for removal and it is approved by the contractor.

Class C Major Restorative Services

• Sedative restorations;

• Cast crowns with resin facings;

• Protective restoration;

• Composite resin inlays;

• Services or treatment for the provision of an initial prosthodontic appliance (i.e., fixed bridge restoration, implants, removable partial or complete denture, etc.) when it replaces natural teeth extracted or missing, including congenital defects, prior to the effective date of coverage are not eligible for coverage.

Class C Endodontic Services

• Incomplete endodontic therapy due to the patient's discontinuation of treatment;

• A paste-type root canal filling incorporating formaldehyde or paraformaldehyde;

• Endodontic procedures in conjunction with overdentures;

• Incompletely filled root canals, other than for reason of an inoperable or fractured tooth;

Class C Prosthodontic Services

• Cast unilateral removable partial dentures are not covered benefits;

• Implants, when placed for a removable denture;

• Services or treatment for the provision of an initial prosthodontic appliance (i.e., fixed bridge restoration, implants, removable partial or complete denture, etc.) when it replaces natural teeth extracted or missing, including congenital defects, prior to the effective date of coverage are not eligible for coverage.

Class D Orthodontic Services

• Myofunctional therapy is integral to orthodontic treatment and is not payable as a separate benefit;

• Orthodontic services for dependent children age 19 and older;

• Orthodontic services for adults;

General Services

• Deep sedation/general anesthesia and intravenous conscious sedation without a report;

Adjunctive Services

• Adjunctive dental services, except as described in the General Services section of this plan brochure.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

To avoid delay in the payment of your claims please have your dental provider submit your claims directly to Delta Dental's Federal Employees Dental Program for payment.

Delta Dental's Federal Employees Dental Program network providers will submit your claims directly to Delta Dental's Federal Employees Dental Program. If you would like to submit a paper claim, you may download a claim form from the website at deltadentalfeds.org. Mail completed claim forms to:

Delta Dental of California
Federal Employees Dental Program
PO Box 537007
Sacramento, CA 95853-7007

When a claimant files a claim for dental insurance benefits described in this plan brochure, the claim should be sent to us within 12 months of the date of service. If the claim is not submitted within the time limits described in this section, the delay may cause a claim to be denied or reduced.

International Claims

For services you receive outside of the 50 United States, the District of Columbia or Puerto Rico, send itemized bills/receipts that include an English translation and the date the services were rendered. Benefits will be calculated using the daily rate of exchange for the date of service and reimbursed in United States currency. International participants will receive out-of-network benefits when services are performed by an internationally located provider. All international claims should be submitted to Delta Dental of California, Federal Employees Dental Program, PO Box 537007, Sacramento, CA 95853-7007.

It is to your benefit to reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond. See Section 6 International Services and Supplies for more information.

Deadline for Filing Your Claim

Send us all of the documents for your claims as soon as possible. You must submit your claim to us within 12 months following the delivery of the services in order for them to be considered for plan benefits, unless timely filing was prevented by administrative operations of the Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

We may require, at our option, supporting documentation such as clinical reports, charts, and/or x-rays.

Disputed Claims Process

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

Disputed Claim Steps:

1. Ask us in writing to reconsider our initial decision. You must include any pertinent information omitted from the initial claim filing and mail your additional proof to us within 90 days from the date of receipt of our decision.

2. Send your request for reconsideration to:

Delta Dental of California
Federal Employees Dental Program
Claims Appeals
PO Box 537015
Sacramento, CA 95853-7015

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

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

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

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

HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is required by law to inform you of how Delta Dental and its affiliates ("Delta Dental") protect the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as individually identifiable information regarding a patient's health care history, mental or physical condition or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Delta Dental receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We follow the privacy practices described in this notice and federal and state privacy requirements that apply to our administration of your benefits. Delta Dental reserves the right to change our privacy practice effective for all PHI maintained. We will update this notice if there are material changes and redistribute it to you within 60 days of the change to our practices. We will also promptly post a revised notice on our website. A copy may be requested anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Delta Dental program and will be informed on how to obtain a copy at least every three years.

PERMITTED USES AND DISCLOSURES OF YOUR PHI

Uses and disclosures of your PHI for treatment, payment or health care operations

For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.

Your explicit authorization is not required to disclose information about yourself for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or plan sponsor to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services for Delta Dental to administer your benefits, and who have signed a contract agreeing to protect the confidentiality of your PHI, and have implemented privacy policies and procedures that comply with applicable federal and state law.

Some examples of disclosure and use for treatment, payment or operations include: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Some other examples are:

- Uses and/or disclosures of PHI in facilitating treatment. *For example, Delta Dental may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment. *For example, Delta Dental may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations. *For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.*

Other permitted uses and disclosures without an authorization

We are permitted to disclose your PHI upon your request or to your authorized personal representative (with certain exceptions) when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Delta Dental may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Some other examples include: to notify or assist in notifying a family member, another person, or a personal representative of your condition; to assist in disaster relief efforts; to report victims of abuse, neglect or domestic violence to appropriate authorities; for organ donation purposes; to avert a serious threat to health or safety; for specialized government functions such as military and veterans activities; for workers' compensation purposes; and, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting, provided it does not contain genetic information. Information can also be de-identified or summarized so it cannot be traced to you and, in selected instances, for research purposes with the proper oversight.

Disclosures Delta Dental makes with your authorization

Delta Dental will not use or disclose your PHI without your prior written authorization unless permitted by law. You can later revoke that authorization, in writing, to stop the future use and disclosure. The authorization will be obtained from you by Delta Dental or by a person requesting your PHI from Delta Dental.

YOUR RIGHTS REGARDING PHI

You have the right to request an inspection of and obtain a copy of your PHI.

You may access your PHI by contacting Delta Dental at the address at the bottom of this notice. You must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. Delta Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or x-rays, is returned by Delta Dental to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact Delta Dental as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI.

You have the right to ask that we limit how we use and disclose your PHI, however, you may not restrict our legal or permitted uses and disclosures of PHI. While we will consider your request, we are not legally required to accept those requests that we cannot reasonably implement or comply with during an emergency. If we accept your request, we will put our understanding in writing.

You have the right to correct or update your PHI.

You may request to make an amendment of PHI we maintain about you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have rights related to the use and disclosure of your PHI for marketing.

Delta Dental agrees to obtain your authorization for the use or disclosure of PHI for marketing when required by law. You have the opportunity to opt out of marketing that is permitted by law without an authorization. Delta Dental does not use your PHI for fundraising purposes.

You have the right to request or receive confidential communications from us by alternative means or at a different address.

Alternate or confidential communication is available if disclosure of your PHI to the address on file could endanger you. You may be required to provide us with a statement of possible danger, as well as specify a different address or another method of contact. Please make this request in writing to the address noted at the end of this notice.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. Please contact us at the number at the end of this notice if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by email.

A copy of this notice is posted on the Delta Dental website. You may also request an email copy or paper copy of this notice by calling our Customer Service number listed at the bottom of this notice.

You have the right to be notified following a breach of unsecured protected health information.

Delta Dental will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

COMPLAINTS

You may file a complaint to Delta Dental and/or to the U. S. Secretary of Health and Human Services if you believe Delta Dental has violated your privacy rights. Complaints to Delta Dental may be filed by notifying the contact below. We will not retaliate against you for filing a complaint.

CONTACTS

You may contact Delta Dental at 855-410-3255, or you may write to the address listed below for further information about the complaint process or any of the information contained in this notice.

Delta Dental

PO Box 997330

Sacramento, CA 95899-7330

This notice is effective on and after January 1, 2016.

Note: Delta Dental's privacy practices reflect applicable federal law as well as known state law and regulations. If applicable state law is more protective of information than the federal privacy laws, Delta Dental protects information in accordance with the state law.

LANGUAGE ASSISTANCE

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at the Member/Customer Service telephone number on the back of your Delta Dental ID card, or 1-855-410-3255.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda gratuita, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Delta Dental o al 1-855-410-3255. (Spanish)

Last Significant Changes to this Notice:

- Clarified that Delta Dental does not used your PHI for fundraising purposes – effective January 1, 2016
- Clarified that Delta Dental's privacy policy reflect federal and state requirements – effective January 1, 2015
- Updated contact information (mailing address and phone number) – effective July 1, 2013
- Updated Delta Dental's duty to notify affected individuals if a breach of their unsecured PHI occurs – effective July 1, 2013
- Clarified that Delta Dental does not and will not sell your information without your express written authorization – effective July 1, 2013
- Clarified several instances where the law requires individual authorization to use and disclose information (e.g., fundraising and marketing as noted above) – effective July 1, 2013

DELTA DENTAL AND ITS AFFILIATES

Delta Dental of California offers and administers fee-for-service dental programs for groups headquartered in the state of California.

Delta Dental of New York offers and administers fee-for-service programs in New York.

Delta Dental of Pennsylvania and its affiliates offer and administer fee for-service dental programs in Delaware, Maryland, Pennsylvania, West Virginia and the District of Columbia. Delta Dental of Pennsylvania's affiliates are Delta Dental of Delaware; Delta Dental of the District of Columbia and Delta Dental of West Virginia.

Delta Dental Insurance Company offers and administers fee-for-service dental programs to groups headquartered or located in Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas and Utah and vision programs to groups headquartered in West Virginia.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, ME, MI, NC, NH, OK, OR, RI, SC, SD, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN and WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania; VA — Delta Dental of Virginia. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Dentegra Insurance Company.

Section 9 Definitions of Terms We Use in This Brochure

Alternate Benefit	If we determine a service less costly than the one performed by your dentist could have been performed by your dentist, we will pay benefits based upon the less costly services. See Section 3 How You Get Care for a definition of alternate benefit.
Annual Benefit Maximum	The maximum annual benefit that you can receive per person.
Annuitants	Federal retirees (who retired on an immediate annuity) and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Calendar Year	From January 1, 2017 through December 31, 2017. Also referred to as the plan year.
Class A Services	Basic services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and X-rays.
Class B Services	Intermediate services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
Class C Services	Major services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
Class D Services	Orthodontic services.
Coinsurance	Coinsurance is the stated percentage of covered expenses you must pay.
Copay/Copayment	A copayment is a fixed amount of money you pay to the provider when you receive services.
Cosmetic Procedure	A cosmetic procedure is any procedure or portion of a procedure performed primarily to improve physical appearance or is performed for psychological purposes.
Covered Service	Covered services shall include only those services specifically listed in Section 5 Dental Services and Supplies. A covered service must be incurred and completed while the person receiving the service is a covered person. Covered services are subject to plan provisions for exclusions and limitations and meet acceptable standards of dental practice as determined by us.
Date of Service	The calendar date on which you visit the dentist's office and services are rendered.
Enrollee	The Federal employee or annuitant enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Generally Accepted Dental Protocols	Dental Necessity means that a dental service or treatment is performed in accordance with generally accepted dental standards, as determined from multiple sources including but not limited to relevant clinical dental research from various research organizations including dental schools, current recognized dental school standard of care curriculums and organized dental groups including the American Dental Association, which is necessary to treat decay, disease or injury of teeth, or essential for the care of teeth and supporting tissues of the teeth.

Incur/Incurred	A covered service is deemed incurred on the date care, treatment or service is received.
Maximum Allowable Charge	Maximum Allowed Charge means the contracted or billed amount of the dental charge whichever is the lesser.
Network Allowance	Network Allowance means the allowance per procedure that Delta Dental's Federal Employees Dental Program has negotiated with the provider and they have agreed to accept as payment in full for his/her services.
Plan	Delta Dental's Federal Employees Dental Program
Plan Allowance	The amount we use to determine our payment for services. If services are provided by an in-network dentist the Plan Allowance is based on the discounted fee he or she accepts as payment in full for the procedure or procedures. If services are provided by an out-of-network dentist the Plan Allowance is based on Delta Dental's Federal Employees Dental Program's determination of usual and customary charges for the procedure or procedures.
Pre-Treatment Estimate	This is the procedure used by the plan to estimate covered services and the amount that the plan will cover. It is not a guarantee of payment.
"Tooth Missing but Not Replaced" Rule	The installation of complete or partial removable dentures, fixed partial dentures (bridges), implants, and other prosthodontic services will be covered when replacing or repairing a pre-existing, failed prosthodontic appliance/device that was in existence prior to your coverage effective date under the Delta Dental Federal Employees Dental Program. Initial prosthodontic services to replace natural teeth that were missing prior to your Delta Dental Federal Employees Dental Program date of coverage are not covered.
Waiting Period	The amount of time that you must be enrolled in this plan before you can receive orthodontic services.
We/Us	Delta Dental's Federal Employees Dental Program
You	Enrollee or eligible family member.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Dental 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, Delta Dental's Federal Employees Dental Program, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your Explanation of Benefits (EOB) statements.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 855-410-3255 and explain the situation, you will be required to state your complaint in writing to us.
- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless 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 plan 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 details, please review the individual sections of this plan brochure.
- If you want to enroll or change your enrollment in this plan, please visit www.BENEFEDS.com or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680.

High Option Benefits	You Pay In-network	You Pay Out-of-network	Page
Class A Basic Services – preventive and diagnostic	**0%**	**10%** of the plan allowance and any difference between our allowance and the billed amount.	16
Class B Intermediate Services – includes minor restorative services	**30%**	**40%** of the plan allowance and any difference between our allowance and the billed amount.	18
Class C Major Services – includes major restorative, endodontic, and prosthodontic services	**50%**	**60%** of the plan allowance and any difference between our allowance and the billed amount.	22
Class D Orthodontic Services $2,000 Lifetime Maximum	**50%**	**50%** of the plan allowance and any difference between our allowance and the billed amount.	28

Please Note: Class A, B, and C services in the High Option are subject to a $4,000 annual maximum benefit in-network and a $3,000 annual maximum benefit out-of-network.

Standard Option Benefits	You Pay In-network	You Pay Out-of-network	Page
Class A Basic Services – preventive and diagnostic	**0%**	**40%** of the plan allowance and any difference between our allowance and the billed amount.	16
Class B Intermediate Services – includes minor restorative services	**45%**	**60%** of the plan allowance and any difference between our allowance and the billed amount.	18
Class C Major Services – includes major restorative, endodontic, and prosthodontic services	**65%**	**80%** of the plan allowance and any difference between our allowance and the billed amount.	22
Class D Orthodontic Services $2,000 Lifetime Maximum Or a $1000 Lifetime Maximum for out-of-network	**50%**	**50%** of the plan allowance and any difference between our allowance and the billed amount.	28

Please Note: Class A, B, and C Services in the Standard Option are subject to a $1,500 annual maximum benefit in-network and a $600 annual maximum benefit out-of-network .

Notes

Notes

Notes

Rate Information

How to find your rate

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

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

State		Rating Area	State		Rating Area	State		Rating Area
AK	Entire state	5	MD	219	4	PA	Rest of state	2
AL	Entire state	1	MD	Rest of state	5	PR	Entire area	1
AR	Entire state	2	ME	Entire state	5	RI	Entire state	5
AZ	Entire state	5	MI	Entire state	4	SC	Entire state	5
CA	Entire state	5	MN	Entire state	4	SD	Entire state	5
CO	Entire state	4	MO	Entire state	4	TN	Entire state	1
CT	Entire state	5	MS	Entire state	1	TX	739	3
DC	Entire area	5	MT	Entire state	1	TX	Rest of state	2
DE	Entire state	4	NC	Entire state	2	UT	Entire state	5
FL	Entire state	4	ND	Entire state	1	VA	200-205, 220-227	5
GA	Entire state	2	NE	Entire state	1	VA	Rest of state	3
GU	Entire area	5	NH	Entire state	5	VI	Entire area	5
HI	Entire state	5	NJ	080-084	4	VT	Entire state	5
IA	Entire state	4	NJ	Rest of state	5	WA	Entire state	5
ID	Entire state	5	NM	Entire state	4	WI	540	4
IL	Entire state	2	NV	Entire state	5	WI	Rest of state	5
IN	463-464	2	NY	Entire state	5	WV	254	5
IN	Rest of state	1	OH	Entire state	1	WV	Rest of state	2
KS	Entire state	4	OK	Entire state	3	WY	Entire state	5
KY	Entire state	1	OR	Entire state	5	INTER	International	5
LA	Entire state	1	PA	173-174, 183	5			
MA	Entire state	5	PA	189-196	4			

Monthly Rates

Rating Areas	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
1	$36.38	$72.76	$109.14	$19.09	$38.18	$57.27
2	$39.89	$79.76	$119.64	$20.78	$41.58	$62.36
3	$43.72	$87.45	$131.17	$22.40	$44.79	$67.21
4	$46.50	$93.02	$139.53	$23.62	$47.19	$70.81
5	$54.06	$108.14	$162.20	$26.95	$53.91	$80.86

Bi-weekly Rates

Rating Areas	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
1	$16.79	$33.58	$50.37	$8.81	$17.62	$26.43
2	$18.41	$36.81	$55.22	$9.59	$19.19	$28.78
3	$20.18	$40.36	$60.54	$10.34	$20.67	$31.02
4	$21.46	$42.93	$64.40	$10.90	$21.78	$32.68
5	$24.95	$49.91	$74.86	$12.44	$24.88	$37.32