The MetLife Federal Dental Plan

http://federaldental.metlife.com

MetLife

2012

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

This Plan has 6 enrollment regions, including international; please see the end of this brochure to determine your region and corresponding rates

Purdue University Certified Center of Excellence 2005, 2006, 2007, 2008, 2009 & 2010.

FCS Portfolio Awards, Business Collateral Award; Gold Award in 2008, & Bronze Award in 2009

2010 Stevie Award for Business to Business Advertising Campaign of the Year.

FEDVIP
Federal Employees
Dental And Vision Insurance Program

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The 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 The MetLife Federal Dental Plan under Metropolitan Life Insurance Company (MetLife) contract OPM-06-00060-6 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

MetLife

501 US Highway 22

Bridgewater, NJ 08807

(888) 865-6854 TDD (888) 260-5376

federaldental.metlife.com

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits. **You and your family members do not have a right to benefits that were available before January 1, 2012 unless those benefits are also shown in this brochure.**

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

The MetLife Federal Dental Insurance Plan is responsible for the selection of In-Network providers in your area. Contact us at (888) 865-6854 TDD (888) 260-5376 for the names of participating providers or to request a provider directory. You may also view current In-Network providers via our web site at federaldental.metlife.com. Continued participation of any specific provider cannot be guaranteed. Thus, you should make coverage decisions based on the plan benefits, not based on a specific provider. When you phone for an appointment, please remember to verify that the provider is currently in the MetLife PDP network. If your provider is not currently participating in the provider network, you can ask him or her to join; or ask your dentist to visit www.metdental.com or call (877) MET-DDS9. Note this website and phone number are specifically for dentists and not accessible to employees/annuitants. You cannot change plans, outside of Open Season, because of changes to the provider network.

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

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

We want you to know that protecting the confidentiality of your individually identifiable health information is of the utmost importance to us. To review full details about our privacy practices, our legal duties, and your rights, please visit our website at federaldental.metlife.com and link to the "Privacy Policy" at the bottom MetLife Federal Dental's home page. If you do not have access to the internet or would like further information, please contact us by calling 1-888-865-6854. Furthermore, you may view the HIPAA information and other personal health information beginning on page 42 of this document.

How We Have Changed for 2012

- The High Option Annual Benefit Maximum for non-orthodontic services has increased from $5,000 to 10,000 combined for both in and out of network services.
- The High Option Orthodontia plan maximum has increased from $3,000 to $3,500 combined for both in and out of network services. This new $3,500 lifetime maximum will be for a dependent child's orthodontia course/phase of treatment that begins on 1/1/2012 or after.
- Benefits for codes D0330, D0340, D0350, and D0470 will be applied to the lifetime orthodontia maximum when performed as part of orthodontia treatment; for those dependents eligible for Class D benefits who have satisfied the 24 month orthodontic waiting period for services rendered on or after 1/1/2012.
- International participants will receive an in-network benefit when services are performed by an out-of -network internationally located provider.

Table of Contents

FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas regional, dental Preferred Provider Organizations (PPO), 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/insure/dental or www.opm.gov/insure/vision for more information.
Enroll Through BENEFEDS	You enroll through the Internet at www.BENEFEDS.com. Please see Section 2, Enrollment, for more information.
Dual Enrollment	If you or one of your family members are 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
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2011 Open Season, your coverage will begin on January 1, 2012. Premium deductions will start with the first full pay period beginning on/after January 1, 2012. 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, 2011 through December 12, 2011. 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 dependent child receiving orthodontia services must be enrolled in the same plan option for an entire and continuous 24 month waiting period to receive orthodontic coverage when enrolled in that same plan option. Any change in the plan option will result in the dependent having to satisfy a new 24 month waiting period, for that plan option, in order to be eligible for orthodontic services. A re-enrollment into the MetLife Federal Dental Plan, after returning from another FEDVIP dental carrier, will require the dependent to satisfy a new 24 month orthodontia waiting period for that elected plan option."

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. Enrollment in the FEHB Program 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.

Advise BENEFEDS of your new payroll office number.

Survivor Annuitants

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

Compensationers

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

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, see the FEHB Handbook at www.opm.gov/insure/handbook, visit the website at (http://www.opm.gov/insure/dental) or (http://www.opm.gov/insure/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 2012.

Note: You cannot enroll 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 are 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

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee or an eligible annuitant, you can enroll in a dental and/or vision plan during the November 14 through December 12, 2011 Open Season. Coverage is effective January 1, 2012.

During future annual Open Seasons, you may enroll in a plan, or change or cancel your dental and/or vision coverage. The effective date of these Open Season enrollments and changes will be set by OPM. If you want to continue your current enrollment, do nothing. Your enrollment carries over from year to year, unless you change it.

New hire/Newly eligible

You can enroll within 60 days after you become eligible as:

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

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

Qualifying Life Event

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

The following chart lists the QLE's and the enrollment actions you may take.

Qualifying Life Event	From Not Enrolled to Enrolled	INCREASE: Enrollment Type	DECREASE: Enrollment Type	Cancel	CHANGE: from one plan to another
Acquiring an eligible family member	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 pay status (enrollee or spouse)	No	No	No	Yes	No
Returning to pay status from active military duty (enrollee or spouse)	Yes	No	No	No	No
Annuity/ compensation restored	Yes	Yes	Yes	No	No
Transferring to an eligibile Federal agency*	No	No	No	Yes	No

*Federal agency must provide dental and/or vision coverage with 50 percent or more employer-paid premium.

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

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

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 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 haven't yet elapsed. That means once you have enrolled in either a dental or a vision plan, you cannot change or cancel that particular enrollment until the next Open Season, unless you experience a QLE that allows such a change or cancellation.

Canceling an enrollment

You can 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.

Note: Coverage ends for a covered individual when MetLife does not receive premium payment for that covered individual.

Continuation of Coverage

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

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

However, we will pay benefits for a 31 day period after your insurance ends if before coverage ends the dentist:

- prepared the abutment teeth for the completion of installation of prosthetic devices;
- made an impression;
- prepared the tooth for cast restoration; or
- your dentist opened the pulp chamber before your insurance ends and the device is installed or treatment was finished within 31 days after the termination of coverage.

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.

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.

Current FSAFEDS participants must re-enroll to participate in 2012. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-800-952-0450.

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 the MetLife Federal Dental Plan to the FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Heath 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 card 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. If you require a replacement ID card, you will be able to view and print your ID card via MyBenefits after entering federaldental.metlife.com. An ID card is neither a guarantee of benefits nor does your provider need it to render dental services. Your dentist may call (877) 638-3379 to confirm your enrollment in the Plan and the benefits available to you. If you were enrolled in the MetLife Federal Dental Plan in 2011 and continue coverage for 2012, MetLife will provide you with a confirmation letter only.
Where You Get Covered Care	You can obtain care from any licensed dentist in the United States or overseas.
Plan Providers	We list our Plan providers on our website at: federaldental.metlife.com which we update weekly. When you make your appointment please advise the dentist office that you are enrolled in the FEDVIP plan and wish to use your In-Network benefits. This will also serve to confirm that the dentist is a MetLife provider. You may also contact customer service at (888) 865-6854.
In-Network	An employee is not required to select a primary care dentist. Employees are free to select the dentist of their choice. Plan benefits are available, subject to plan provisions, whether the dentist participates in our network or not. If you use a MetLife 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 for these additional treatment charges. MetLife's network consists of independently credentialed and contracted providers. To find a dentist in your area go to: federaldental.metLife.com. You may also contact customer service at (888) 865-6854.
Out-of-Network	All plan designs allow for Out-of-Network benefits for the patient. Allowable charges will be based on the 80th percentile of our Usual and Customary charges.
Emergency Services	All expenses for emergency services are payable as any other expense. If you utilize the services of an Out-of-Network dentist 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 billed charges.
Plan Allowance	The Plan Allowance is the amount we allow for a specific procedure. When you use a participating provider, your out-of-pocket 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 the Plan allowance and our payment plus the difference between the amount the provider bills and the Plan allowance.
Pre-Certification	Pre-certification (Pre-determination) of benefits procedure is recommended for any procedure which is anticipated to cost at least $300 or which involves mandatory consultant review. Mandatory consultant review applies to such services as but not limited to, periodontal services, crowns, bridges, inlays/onlays (when performed together) veneers, implants (when a plan provides benefits for these procedures) and overdentures, among other services.
Alternate Benefit	Alternate benefits applicable to your treatment plan will be determined during Pre-certification. However, should the services billed differ from those pre-certified, MetLife reserves the right to determine if an Alternate Benefit is applicable to the actual services rendered.

If MetLife determines that a less costly covered service other than the covered service the dentist performed could have been performed to treat a dental condition we will pay benefits based upon the less costly service if such service would produce a professionally acceptable result under generally accepted dental standards

For example, when an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, or when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch we may base our benefit determination upon the amalgam filling or partial denture which is the less costly service.

If we pay benefits based upon a less costly service in accordance with this section the Dentist may charge you or your dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network dentist.

Dental Review

MetLife's claim review is conducted by licensed Dentist Consultants who review the clinical documentation submitted by your treating dentist. These Dentist Consultants review this material checking for dental necessity for certain procedures such as crowns, bridges, onlays, implants, periodontal treatments, as well as other services. The Dentist Consultants may also recommend that an alternate benefit be applied to a service in accordance with the terms of the plan, therefore, it is very important that these types of dental services are pre-determined for benefits, so that, you and you dentist are aware of the coverage terms and benefits before services are performed.

First Payor

If you have dental coverage through your FEHB plan and coverage under FEDVIP, your FEHB plan will be the first payor of any benefit payments. When services are rendered by a provider, who participates with both your FEHB and your FEDVIP plan, the FEDVIP plan allowance will be the prevailing charge, in these cases. We are responsible for facilitating the process with the primary FEHB payor. You are responsible for the difference between the FEHB and FEDVIP benefit payments and the FEDVIP plan allowance. See examples 1 and 2 below.

It is important to bring your FEDVIP and FEHB identification cards to every dental appointment because most FEHB plans offer some level of dental benefits separate from your FEDVIP coverage. Presenting both identification cards can ensure that you receive the maximum allowable benefit under each Program.

Example 1: High- Option coverage when services are provided by an In-Network provider

When the covered individual has FEHB coverage that offers dental benefits, FEHB is always First Payor.	**Services are provided by an In-Network Provider**
Provider submitted charge for a one surface amalgam filling*	$108.00
In-network fee	$60.00
FEHB paid as first payor (or MetLife' estimate)	$16.00
MetLife benefits payable in the absence of FEHB coverage	$42.00 ($60.00 at 70%)
Payment by MetLife	$42.00
Patient's responsibility to the provider	$2.00 ($60.00 - $16.00 -$42.00 = $2.00)
**This example assumes all deductibles have been met and annual maximums have not been reached.*	

Example 2: High Option coverage when services are performed by an Out-of-Network provider

When the covered individual has FEHB coverage that offers dental benefits, FEHB is always First Payor.	Services are provided by an Out-of - Network Provider
Provider submitted charge for one surface amalgam filling *	$108.00
In-Network Fee	N/A
FEHB payment as first payor (or MetLife's estimate)	$16.00
MetLife benefits payable in the absence of FEHB coverage	$64.80 ($108 x 60%)
Payment by MetLife **	$64.80
Patient's responsibility to provider **	$27.20 ($108.00 - $16.00 - $64.80 = $27.20)
*This example assumes all deductibles have been met and annual maximums have not been reached.	**Assumes the provider charge is withinMetLife's Usual and Customary guidelines.

Coordination of Benefits

If you are covered under a non-FEHB plan, your MetLife Federal Dental benefits will be coordinated using traditional COB provisions for determining payment. Please see examples 1 and 2 below.

When benefits are coordinated between MetLife and a non-FEHB carrier, the maximum allowable charge may vary depending upon the contractual relationship and contracted fee between MetLife and non-FEHB carrier. The participant may be responsible for the difference between the combined non-FEHB and MetLife benefit payment and the providers' allowable charge.

Example 1: High Option coverage when services are performed by an In-Network provider.

When MetLife is secondary to a non-FEHB dental carrier.	Services are provided by an In-NetworkProvider
Provider submitted charge for two surface amalgam filling	$121.00
In-network Fee	$73.00
Payable by Primary Carrier.	$60.50
MetLife benefits payable in the absences of other insurance*	$51.10 ($73.00 at 70%)
Payment by MetLife	$12.50
Patient's responsibility to the provider **	$0 ($73.00 - $60.50 - $12.50 = $0.00)
*This example assumes all deductibles have been met and annual maximums have not been reached.	** Assumes the provider has no other contractual relationship regarding negotiated fees with the primary carrier.

Example 2: Coordination of Benefits with High-Option coverage where services are provided by an Out-of-Network provider.

When MetLife is secondary to a non-FEHB carrier	Services are provided by an Out-of-network Provider
Provider submitted charge for 2 surface amalgam fillings	$121.00
In-Network Fee	N/A
Payment of Primary Carrier.	$96.80
MetLife benefits payable in the absence of other insurance*	$72.60 ($121.00 x 60%)
Payable by MetLife	$24.20
Patient's responsibility to the provider **	$0 ($121.00 - $96.80 - $24.20 = $0)
**This example assumes all deductibles have been met and annual maximums have not been reached.*	***Assumes the provider charge is within MetLife's Usual and Customary guidelines.*

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.

The amount of the payment includes the reasonable cash value of any benefits provided in the form of services. However, in no circumstance will the member be responsible for a greater out of pocket amount then 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. Your rates might change because of the move. Your rates will not be impacted if you temporarily reside at another location

Limited Access Area

If you live in a limited access area and you receive covered services from an Out-of-Network provider, we will pay benefits based on our In-Network Plan Allowances. The determination of network adequacy is based on a ratio of Federal eligibles to network and general dentistry providers in a particular area. To determine if you are in a limited access area or specialty services are needed, please contact MetLife at (888) 865-6854 or TDD (888) 260-5376. MetLife reviews the limited access areas quarterly to ensure you have adequate access to our general dentistry in-network providers. Therefore, we recommend you call (888) 865-6854 to confirm if you are still in a limited access area as your claim payment may be impacted. The limited access rule only applies to general dentistry providers and does not apply to specialist providers in any area. If the services must be provided by a Specialist and one is not available in your area, please call us for assistance. If an in-network provider (general or specialist) can perform a specialty service, then that service will be covered at the in-network benefit. Please contact MetLife at (888) 865-6854 or visit our website at federaldental.metlife.com to obtain a list of in-network general dentists in your area, who may be able to perform specialty services.

Claim Determination Period

A period that starts on any January 1 and ends on the next December 31. A claim determination period for any covered person will not include the periods of time during which that person is not covered under this Plan.

Should you experience a lapse in coverage during the calendar year, any benefits paid after reinstatement will be accrued to the maximums applicable to that same calendar year.

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	$50	$100
Class B	$0	$0	$50	$100
Class C	$0	$0	$50	$100
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	$10,000	$1,200	$10,000	$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	$3,500	$1,500	$3,500	$1,000

In-Network Services

There is no requirement to use a participating provider. However, In-Network plan benefits will be paid if you use the services of a participating provider. In most cases this results in a lower out-of-pocket expense to you. No referral process is needed for access to specialty care.

If you reside in a limited access area your benefits will be paid at the In-Network benefit level.For additional information on limited access areas, please see Section 3, How You Obtain Care.

If your participating (PDP) dentist decides to terminate his or her relationship with MetLife all treatments that began prior to the termination will be payable at the in-network level of benefits. All new treatment or treatment plans that do not start prior to the termination are payable at the Out-of-Network level of benefits. Remember, for In-Network services you only pay the difference between the Plan Allowance and the plan payment.

Out-of-Network Services

All services rendered by an out-of-network dentist will be paid will be paid as out-of-network benefits, except for limited access benefits. All benefits are payable based on the 80th percentile of MetLife's usual and customary charges for a dentist in your area.

Calendar Year

The calendar year refers to the plan year, which is defined as January 1, 2012 to December 31, 2012.

Prorated Orthodontia Benefits

When orthodontic services are initiated prior to the end of the waiting period we will prorate our benefits. Twenty five percent (25%) of the Plan allowance is considered as the fee for initial placement of the appliance. Because this occurred prior to the end of the waiting period it is considered a non covered expense. The balance of the Plan Allowance, 75%, will be divided by the total number of monthly visits provided in the orthodontist's treatment plan. Benefits are payable at 50% of the Plan Allowance.

- **Standard Option In-Network Benefits**

Actual Fee	$6,500	
In-Network Fee	$4,300	
Treatment Plan	18 visits	
Number of monthly visits prior to the end of the waiting period	10	
Number of covered monthly visits	8	18 total visits minus10 provided prior to end of waiting period
Maximum Allowable Fee	$3,000	
Plan Allowance for initial placement	$750	$3,000 x 25%=$750 (This is a non-covered expense as it occurred prior to the end of the waiting period)
Plan Allowance for monthly visits	$2,250	$3000 - $750 = $2,250
Plan Allowance per visit	$125	$2250 divided by 18
Total Plan Allowance for covered visits	$1000	$125 times 8 covered visits
Total Plan Payment	$500	Benefit is 50% of Plan Allowance for covered services

- **Standard Option Out-of-Network Benefits**

Actual Fee	$5,800	
In-Network Fee	$0	Out-of-Network Provider
Treatment Plan	24 visits	
Number of monthly visits prior to the end of the waiting period	14	
Number of covered monthly visits	10	24 total visits minus14 provided prior to end of waiting period
Maximum Allowable Fee	$2,000	
Plan Allowance for initial placement	$500	$2,000 x 25% = $500. (This is a non-covered expense as it occurred prior to the end of the waiting period)
Plan Allowance for monthly visits	$1,500	$2,000 – $500 = $1,500
Plan Allowance per visit	$62.50	$1500 divided by 24
Total Plan Allowance for covered visits	$625	$62.50 x 10 covered visits
Total Plan Payment	$312.50	Benefit is 50% of Plan Allowance for covered services

- **High Option In-Network Benefits**

Actual Fee	$6,500	
In-Network Fee	$4,300	
Treatment Plan	18 visits	
Number of monthly visits prior to the end of the waiting period	10	
Number of covered monthly visits	8	18 total visits minus10 provided prior to end of waiting period
Maximum Allowable Fee	$4,300	
Plan Allowance for initial placement	$1,075	$4,300 x 25% = $1,075 (This is a non-covered expense as it occurred prior to the end of the waiting period)
Plan Allowance for monthly visits	$3,225	$4,300 – $1,075= $3,225
Plan Allowance per visit	$179	$3,225 divided by 18
Total Plan Allowance for covered visits	$1,432	$179 x 8 covered visits
Total Plan Payment	$716	Benefit is 50% of Plan Allowance for covered services

- **High Option Out-of-Network Benefit**

Actual Fee	$7,500	
In-Network Fee	$0	Out-of-Network Provider
Treatment Plan	18 visits	
Number of monthly visits prior to the end of the waiting period	10	
Number of covered monthly visits	8	18 total visits minus 10 provided prior to end of waiting period
Maximum Allowable Fee	$7,000	
Plan Allowance for initial placement	$1,750	$7,000 x 25% = $1,750 (This is a non-covered expense as it occurred prior to the end of the waiting period)
Plan Allowance for monthly visits	$5,250	$7,000 – $1,750 = $5,250
Plan Allowance per visit	$292	$5,250 divided by 18
Total Plan Allowance for covered visits	$2,336	$292 x 8 covered visits
Total Plan Payment	$1,168	$2,336 x 50% = $1,168 (Benefit is 50% of Plan Allowance for covered services)

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is $0, if you use an in network provider. There is no family deductible. If you elect to use an Out-of-Network provider, the Standard Option contains a $100 deductible per person, and the High Option has a $50 deductible per person. Neither Option contains a family deductible, each enrolled covered person must satisfy their own deductible. The calendar year deductible may apply to Type A expenses provided by an Out-of-Network provider.
- The Annual Benefit Maximum in the High Option for non-orthodontic services is $10,000, combined, for both In-Network and Out-of-Network services. The Standard Option Annual Benefit Maximum for non-orthodontic services is $1,200 for In-Network services and $600 for Out-of-Network services. In no instance will MetLife allow more than $1,200 in combined benefits under the Standard Option in any plan year.
- All Exams, oral evaluations and treatments such as fluorides are combined under one limitation under the plan. Periodic oral exam, (D0120) Oral evaluations (D0140), and Comprehensive oral exam (D0150. D0180) are combined and limited to one exam in every 6 months from the date services were last rendered. For example, if you have a periodic oral evaluation and a limited oral examination both services are combined, so that, not more than the maximum allowable expense and limitation are paid under the Plan. There must be a six month separation between services, even when the separation of services duration enters a new plan year.
- All services requiring more than one visit are payable once all visits are completed.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7.

You Pay:

- ***High Option***
- **In-Network: Preventive and Diagnostic services – $0 (PDP Fee) for covered services as defined by the Plan subject to Plan deductibles and maximums.**
- **Out-of-Network: Preventive and Diagnostic services - 10% of the Usual and Customary charges for covered services as defined by the Plan subject to Plan deductibles and maximums. You are responsible for the difference between the plan payment and the amount billed by your dentist.**
- ***Standard Option***
- **In-Network: Preventive and Diagnostic Services - $0 (PDP Fee) for covered services as defined by the Plan subject to Plan deductibles and maximums.**
- **Out-of-Network: 40% of the Usual and Customary charges for covered services as defined by the Plan subject to Plan deductibles and maximums. You are responsible for the difference between the plan payment and the amount billed by your dentist.**

Diagnostic and Treatment Services
D0120 Periodic oral evaluation - Limited to 1 every 6 months
D0140 Limited oral evaluation - problem focused - Limited to 1 every 6 months
D0150 Comprehensive oral evaluation - Limited to 1 every 6 months
D0180 Comprehensive periodontal evaluation - Limited to 1 every 6 months
D0210 Intraoral – complete series (including bitewings) 1 every 60 (sixty) months
D0220 Intraoral - periapical first film
D0230 Intraoral - periapical - each additional film
D0240 Intraoral - occlusal film
D0270 Bitewing - single film Adult -1 set every calendar year / Children -1 set every 6 months
D0272 Bitewings - two films - Adult -1 set every calendar year / Children -1 set every 6 months
D0274 Bitewings - four films Adult -1 set every calendar year / Children -1 set every 6 months
D0277 Vertical bitewings – 7 to 8 films – Adult -1 set every calendar year / Children -1 set every 6 months
D0330 Panoramic film – 1 film every 60 (sixty) months
D0340 Cephalometric x-ray
D0350 Oral / Facial Photographic Images
D0470 Diagnostic Models

Note: Diagnostic procedures of: D0330, D0340, D0350 and D0470 are covered as Type A benefit and applied toward the Non-Ortho annual maximum for a non-vested orthodontia participant.

Preventative Services
D1110 Prophylaxis – Adult - Limited to 1 every 6 months
D1120 Prophylaxis – Child - Limited to 1 every 6 months
D1203 Topical application of fluoride (excluding prophylaxis) – child - Limited to 2 every 12 months
D1204 Topical application of fluoride (excluding prophylaxis) – Age 15 to 22 - 2 every 12 months
D1206 Topical fluoride varnish - Over age 22 - 1 in 12 months; Less than age 22 - 2 in 12 months
D1351 Sealant - per tooth - unrestored permanent molars - Less than age 19. 1 sealant per tooth every 36 months
D1352 Preventative resin restorations in a moderate to high caries risk patient - permenant tooth - 1 sealant per tooth every 36 months.
D1510 Space maintainer – fixed – unilateral - Limited to children under age 19
D1515 Space maintainer – fixed – bilateral - Limited to children under age 19
D1520 Space maintainer - removable – unilateral - Limited to children under age 19
D1525 Space maintainer - removable – bilateral - Limited to children under age 19
D1550 Re-cementation of space maintainer - Limited to children under age 19
Additional Procedures covered as Basic Services
D9110 Palliative treatment of dental pain – minor procedure
Services Not Covered:(Please refer to Section 7 for a list of General Exclusions)
D0320 TMJ arthrogram
D0321 Other TMJ films
D0322 Tomographic survey
D0360 Cone Beam CT
D0362 Cone Beam multiple images 2 dim.
D0363 Cone Beam multiple images 3 dim.
D0416 Viral culture
D0418 Analysis of saliva example chemical or biological analysis of saliva for diagnostic purposes.
D0425 Caries test

Services Not Covered:(Please refer to Section 7 for a list of General Exclusions) - continued on next page

Services Not Covered:(Please refer to Section 7 for a list of General Exclusions) (cont.)
D0431 Adjunctive pre-diagnostic test
D0475 Declassification procedure
D0476 Special stains for microorganisms
D0477 Special stains not for microorganisms
D0478 Immunohistochemical stains
D0479 Tissue in-situ-hybridization
D0481 Electron microscopy
D0482 Direct immunofluorescence
D0483 In-direct immunofluorescence
D0484 Consultation on slides prepared elsewhere
D0485 Consultation including preparation of slides
D0486 Accession Transepithelial
D1310 Nutritional counseling
D1320 Tobacco counseling
D1330 Oral Hygiene Instruction
D1555 Removal of fixed space maintainer

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the minor restorative care or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is $0, if you use an In-Network provider. Should you elect to use an out-of -network provider, the Standard Option contains a $100 deductible per covered person, and the High Option has a $50 deductible per covered person. Neither Option contains a family deductible; each enrolled covered person must satisfy his or her own deductible.
- The Annual Benefit Maximum in the High Option for non-orthodontic services is $10,000, combined, for both In-Network and Out-of-Network services. The Standard Option Annual Benefit Maximum for non-orthodontic services is $1,200 for In-Network services and $600 for Out-of-Network services. In no instance will MetLife allow more than $1,200 in combined benefits under the Standard Option in any plan year.
- A number of the services listed in this section may be subject to Dental Review or an Alternate Benefit may be paid. We recommend that your dentist submit a pre-determination for any charges in excess of $300.
- All services requiring more than one visit are payable once all visits are completed.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7.

You Pay:

- ***High Option***
- **In-Network: $0 deductible and then you pay 30% of the Network Allowance (PDP fee) for covered services as defined by the Plan subject to Plan deductibles and maximums.**
- **Out-of-Network: $50 deductible and then you pay 40% of the Usual and Customary charges for covered services as defined by the Plan subject to Plan deductibles and maximums. You are responsible for the difference between the plan payment and the amount billed by your dentist.**
- ***Standard Option***
- **In-Network: $0 deductible and then you pay 45% of the Network Allowance (PDP fee) for covered services as defined by the Plan subject to Plan deductibles and maximums.**
- **Out-of-Network: $100 deductible and then you pay 60% of the Usual and Customary charges for covered services as defined by the Plan subject to Plan deductibles and maximums. You are responsible for the difference between the plan payment and the amount billed by your dentist.**

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

Minor Restorative Services - continued on next page

Minor Restorative Services (cont.)
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)
D2910 Re-cement inlay
D2920 Re-cement crown
D2930 Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months
D2931 Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months
D2940 Protective Restoration
D2951 Pin retention - per tooth, in addition to restoration
Endodontic Services
D3220 Therapeutic pulpotomy (excluding final restoration) - *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - *Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.*
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - *Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.*
Periodontal Services
D4341 Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months
D4342 Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months
D4910 Periodontal maintenance – 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy
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
D5640 Replace broken teeth - per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5710 Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5720 Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5721 Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5730 Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5731 Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5740 Reline maxillary partial denture - Limited to 1in a 36-month period 6 months after the initial installation
D5741 Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D5751 Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5760 Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5761 Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation.
D5850 Tissue conditioning (maxillary)
D5851 Tissue conditioning (mandibular)
D6930 Recement fixed partial denture
D6980 Fixed partial denture repair, by report
Oral Surgery
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220 Removal of impacted tooth - soft tissue
D7230 Removal of impacted tooth – partially bony
D7240 Removal of impacted tooth - completely bony
D7241 Removal of impacted tooth - completely bony with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy - intentional partial tooth removal
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions - per quadrant
D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions - per quadrant
D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess - intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7971 Excision of pericoronal gingiva
Services Not Covered:(Please refer to Section 7 for a list of General Exclusions)
D7292 Surgical replacement screw retained
D7293 Surgical replacement w/surgical flap
D7294 Surgical replacement without the surgical flap
D7880 TMJ Appliance
D7899 TMJ Therapy
D7951 Sinus Augmentation with bone or bone substitutes
D7997 Appliance Removal
D7998 Intraoral placement of a fixation device

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the major restorative care or treatment of a covered condition and meet generally accepted dental protocols.
- All major prosthodonic services are combined under one replacement limitation under the plan. Benefits for prosthodonic services are combined and limited to one every 60 months. For example, if benefits for a partial denture are paid, this includes benefits to replace all missing teeth in the arch. No additional benefits for the arch would be considered until the 60 month replacement limit was met.
- The calendar year deductible is $0 if you use an In-Network provider. Should you elect to use an out-of -network provider the Standard Option contains a $100 deductible per covered person, and the High Option has a $50 deductible per covered person. Neither Option contains a family deductible, each enrolled covered person must satisfy their own deductible.
- The Annual Benefit Maximum in the High Option for non-orthodontic services is $10,000, combined, for both In-Network and Out-of-Network services. The Standard Option Annual Benefit Maximum for non-orthodontic services is $1,200 for In-Network services and $600 for Out-of-Network services. In no instance will MetLife allow more than $1,200 in combined benefits under the Standard Option in any plan year.
- A number of the services listed in this section may be subject to Dental Review or an Alternate Benefit may be paid. MetLife recommends receiving a pre-certification/ pre-determination **prior** to receiving services so you and your dental provider are aware of the coverage terms and benefits**.**
- All services requiring more than one visit are payable once all visits are completed.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7.

You Pay:

- ***High Option***
- **In-Network: $0 deductible and then you pay 50% of the Network Allowance (PDP fee) for covered services as defined by the Plan subject to Plan deductibles and maximums.**
- **Out-of-Network: $50 deductible and then you pay 60% of the Usual and Customary charges for covered services as defined by the Plan subject to Plan deductibles and maximums. You are responsible for the difference between the plan payment and the amount billed by your dentist.**
- ***Standard Option***
- **In-Network: $0 deductible and then you pay 65% of the Network Allowance (PDP fee) for covered services as defined by the Plan subject to Plan deductibles and maximums.**
- **Out-of-Network: $100 deductible and then you pay 80% of the Usual and Customary charges for covered services as defined by the Plan subject to Plan deductibles and maximums. You are responsible for the difference between the plan payment and the amount billed by your dentist.**

Major Restorative Services

Note: When dental services that are subject to a frequency limitation were performed prior to your effective date of coverage the date of the prior service may be counted toward the time, frequency limitations and/ or replacement limitations under this dental insurance.(For example, even if a crown, partial bridge, etc was not placed while covered under MetLife, or paid by MetLife, the frequency limitations may apply).

D0160 Detailed and extensive oral evaluation - problem focused, by report

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

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

D2530 Inlay - metallic – three surfaces – An alternate benefit will be provided

D2542 Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months

D2543 Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months

D2544 Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months

D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months

D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months

D2751 Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months

D2752 Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months

D2780 Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months

D2781 Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months

D2783 Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months

D2790 Crown - full cast high noble metal– Limited to 1 per tooth every 60 months

D2791 Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months

D2792 Crown - full cast noble metal– Limited to 1 per tooth every 60 months

D2794 Crown – titanium– Limited to 1 per tooth every 60 months

D2950 Core buildup, including any pins– Limited to 1 per tooth every 60 months

D2954 Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months

D2980 Crown repair, by report

Endodontic Services

D3310 Anterior root canal (excluding final restoration)

D3320 Bicuspid root canal (excluding final restoration)

D3330 Molar root canal (excluding final restoration)

D3346 Retreatment of previous root canal therapy-anterior

D3347 Retreatment of previous root canal therapy-bicuspid

D3348 Retreatment of previous root canal therapy-molar

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

D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)

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

D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration

D3410 Apicoectomy/periradicular surgery - anterior

D3421 Apicoectomy/periradicular surgery - bicuspid (first root)

D3425 Apicoectomy/periradicular surgery - molar (first root)

D3426 Apicoectomy/periradicular surgery (each additional root)

D3450 Root amputation - per root

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

Periodontal Services
D4210 Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months
D4211 Gingivectomy or gingivoplasty – one to three teeth
D4240 Gingival flap procedure, four or more teeth – Limited to 1 every 36 months
D4249 Clinical crown lengthening-hard tissue
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
D4270 Pedicle soft tissue graft procedure
D4271 Free soft tissue graft procedure (including donor site surgery)
D4273 Subepithelial connective tissue graft procedures (including donor site surgery)
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime
Prosthodontic Services
D5110 Complete denture - maxillary – Limited to 1 every 60 months
D5120 Complete denture - mandibular – Limited to 1 every 60 months
D5130 Immediate denture - maxillary – Limited to 1 every 60 months
D5140 Immediate denture - mandibular – Limited to 1 every 60 months
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)– Limited to 1 every 60 months
D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months
Note: An **implant** is a covered procedure of the plan only if determined to be a dental necessity. MetLife claim review is conducted by a panel of licensed dentists who review the clinical documentation submitted by your treating dentist. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.
D6010 Endosteal Implant - 1 every 60 months
D6012 Surgical Placement of Interim Implant Body - 1 every 60 months
D6040 Eposteal Implant – 1 every 60 months
D6050 Transosteal Implant, Including Hardware – 1 every 60 months
D6053 Implant supported complete denture
D6054 Implant supported partial denture
D6055 Connecting Bar – implant or abutment supported - 1 every 60 months
D6056 Prefabricated Abutment – 1 every 60 months
D6058 Abutment supported porcelain ceramic crown -1 every 60 months
D6059 Abutment supported porcelain fused to high noble metal - 1 every 60 months
D6060 Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months
D6061 Abutment supported porcelain fused to noble metal crown - 1 every 60 months
D6062 Abutment supported cast high noble metal crown - 1 every 60 months
D6063 Abutment supported cast predominately base metal crown - 1 every 60 months
D6064 Abutment supported cast noble metal crown - 1 every 60 months
D6065 Implant supported porcelain/ceramic crown - 1 every 60 months

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6066 Implant supported porcelain fused to high metal crown - 1 every 60 months
D6067 Implant supported metal crown - 1 every 60 months
D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months
D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months
D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months
D6072 Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months
D6073 Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months
D6074 Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months
D6075 Implant supported retainer for ceramic fixed partial denture - 1 every 60 months
D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
D6077 Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
D6078 Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months
D6079 Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 months
D6080 Implant Maintenance Procedures -1 every 60 months
D6090 Repair Implant Prosthesis -1 every 60 months
D6091 Replacement of Semi-Precision or Precision Attachment -1 every 60 months
D6095 Repair Implant Abutment -1 every 60 months
D6100 Implant Removal -1 every 60 months
D6190 Implant Index -1 every 60 months
D6210 Pontic - cast high noble metal – Limited to 1 every 60 months
D6211 Pontic - cast predominately base metal – Limited to 1 every 60 months
D6212 Pontic - cast noble metal– Limited to 1 every 60 months
D6214 Pontic – titanium – Limited to 1 every 60 months
D6240 Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months
D6241 Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months
D6242 Pontic - porcelain fused to noble metal – Limited to 1 every 60 months
D6245 Pontic - porcelain/ceramic – Limited to 1 every 60 months
D6519 Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months
D6520 Inlay – metallic – two surfaces – Limited to 1 every 60 months
D6530 Inlay – metallic – three or more surfaces - Limited to 1 every 60 months
D6543 Onlay – metallic – three surfaces - 1 every 60 months
D6544 Onlay – metallic – four or more surfaces -1 every 60 months
D6545 Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
D6740 Crown - porcelain/ceramic -1 every 60 months
D6750 Crown - porcelain fused to high noble metal - 1 every 60 months
D6751 Crown - porcelain fused to predominately base metal - 1 every 60 months
D6752 Crown - porcelain fused to noble metal - 1 every 60 months
D6780 Crown - 3/4 cast high noble metal - 1 every 60 months
D6781 Crown - 3/4 cast predominately base metal - 1 every 60 months
D6782 Crown - 3/4 cast noble metal - 1 every 60 months
D6783 Crown - 3/4 porcelain/ceramic - 1 every 60 months

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6790 Crown - full cast high noble metal - 1 every 60 months
D6791 Crown - full cast predominately base metal - 1 every 60 months
D6792 Crown - full cast noble metal - 1 every 60 months
D6973 Core buildup for retainer, including any pins - 1 every 60 months
D9940 Occlusal guard, by report - 1 in 12 months for patients 13 and older
Services Not Covered:(Please refer to Section 7 for a list of General Exclusions)
D2410 Gold Foil 1 surface
D2420 Gold Foil 2 surface
D2430 Gold Foil 3 surface
D2799 Provisional Crown
D2955 Post Removal
D2970 Temporary Crown
D2975 Coping
D3460 Endodontic Implant
D3470 Intentional reimplantation
D3910 Surgical procedure for isolation of tooth
D3950 Canal preparation
D4230 Anatomical crown exposure 4 or more teeth
D4231 Anatomical crown exposure 1-3 teeth
D4320 Splinting intracoronal
D4321 Splinting extracoronal
D5810 Complete denture upper (interim)
D5811 Complete denture lower (interim)
D5820 Partial denture upper (interim)
D5821 Partial denture lower (interim)
D5862 Precision Attachment
D5867 Replacement Precision Attachment
D5986 Fluoride Gel Carrier
D6057 Custom abutment
D6253 Provisional Pontic
D6254 Interim pontic
D6795 - Interim retainer crown
D6920 Connector bar
D6940 Stress breaker
D6950 Precision Attachment
D6975 Coping - metal

Class D Orthodontic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is $0 per person.
- The waiting period for orthodontic services is 24 months. To meet this requirement, the dependent child receiving orthodontic services must be covered under the same plan option for the entire 24 month waiting period and continue orthodontia benefits in that same orthodontia vested plan option. Any plan option change will incur a new 24 month orthodontic waiting period. Adults (Members and Spouses) are **NOT** eligible for this orthodontic plan benefit.
- 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. For example, if you are covered by the High Option, the lifetime maximum is $3,500 regardless of the participating status of the provider. In the Standard Option services rendered by an In-Network provider will be subject to a $1,500 lifetime maximum and services rendered by an Out-of-Network provider will be subject to a $1,000 lifetime maximum.
- The benefit payable for the initial placement will not exceed 25% of the Lifetime Maximum Benefit Amount for the appliance. All supplemental payments will be made in equal installments pro-rated over the balance of a maximum period of 29 months. Should your coverage terminate or you reach the orthodontia maximum age of 19, all orthodontia benefit payments will end.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7.

You Pay:

- ***High Option***
- **In-Network: 50% of the Network Allowance (PDP fee) up to the lifetime maximum. You are responsible for all charges that exceed the lifetime maximum.**
- **Out-of-Network: 50% of the Usual and Customary charges up to the lifetime maximum. You are responsible for all charges that exceed the lifetime maximum. You are responsible for the difference between the plan payment and the amount billed by your dentist.**
- ***Standard Option***
- **In-Network: 50% of the Network Allowance (PDP fee) up to the lifetime maximum. You are responsible for all charges that exceed the lifetime maximum.**
- **Out-of-Network: 50% of the Usual and Customary charges up to the lifetime maximum. You are responsible for all charges that exceed the lifetime maximum. You are responsible for the difference between the plan payment and the amount billed by your dentist.**

Orthodontic Services - limited to 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
D8210 Removable appliance therapy
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment visit
D8670 Periodic orthodontic treatment visit (as part of contract)
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)
Note: Benefits for codes D0330, D0340, D0350, and D0470 will be applied to the lifetime orthodontia maximum when performed as part of orthodontia treatment; for those dependents eligible for Class D benefits who have satisfied the 24 month orthodontic waiting period for services rendered on or after 1/1/2012.

Services Not Covered:

(Please refer to Section 7 for a list of General Exclusions)

- Orthodontic care for dependent children age 19 and over
- Orthodontic care for members and spouses
- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliance
- Orthodontic services provided to a dependent of an enrolled member who has not met the 24 month waiting period requirement.
- 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.

General Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, minor restorative care or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is $0 if you use an In-Network provider. Should you elect to use an Out-of-Network provider the Standard Option contains a $100 deductible per covered person, and the High Option has a $50 deductible per covered person. Neither Option contains a family deductible; each enrolled covered person must satisfy his or her own deductible.
- The Annual Benefit Maximum in the High Option for non-orthodontic services is $10,000, combined, for both In-Network and Out-of-Network services. The Standard Option Annual Benefit Maximum for non-orthodontic services is $1,200 for In-Network services and $600 for Out-of-Network services. In no instance will MetLife allow more than $1,200 in combined benefits under the Standard Option in any plan year.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7.

You Pay:

- ***High Option***
- **In-Network: $0 deductible and then you pay 30% of the Network Allowance (PDP Fee) for covered services as defined by the Plan subject to Plan deductibles and maximums.**
- **Out-of-Network: $50 deductible and then you pay 40% of the Usual and Customary charges. for covered services as defined by the Plan subject to Plan deductibles and maximums. You are responsible for the difference between the plan payment and the amount billed by your dentist.**
- ***Standard Option***
- **In-Network: $0 deductible and then you pay 45% of the Network Allowance (PDP Fee) for covered services as defined by the Plan subject to Plan deductibles and maximums.**
- **Out-of-Network: $100 deductible and then you pay 60% of the Usual and Customary charges. for covered services as defined by the Plan subject to Plan deductibles and maximums. You are responsible for the difference between the plan payment and the amount billed by your dentist.**

Anesthesia Services

D9220 Deep sedation/general anesthesia - first 30 minutes

D9221 Deep sedation/general anesthesia - each additional 15 minutes

Intravenous Sedation

D9241 Intravenous conscious sedation/analgesia - first 30 minutes

D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes

Consultations
D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
Medications
D9610 Therapeutic drug injection, by report
Post Surgical Services
D9930 Treatment of complications (post-surgical) unusual circumstances, by report
Services Not Covered: (Please refer to Section 7 for a list of General Exclusions)
D9210 Local Anesthesia not in conjunction with operative or surgical procedures
D9211 Regional Block Anesthesia
D9212 Trigeminal Division Block Anesthesia
D9215 Local Anesthesia
D9230 Analgesia, anxiolysis, inhalation of nitrous oxide
D9248 Non-intravenous conscious sedation
D9410 House / extended care facility call
D9420 Hospital Call
D9450 Case presentation
D9630 Other drugs and or medicaments
D9920 Behavior Management
D9941 Fabrication of athletic mouthguard
D9950 Occlusion analysis - mounted case
D9951 Occlusal adjustment - limited
D9952 Occlusal adjustment - complete
D9970 Enamel microabrasion
D9971 Odontoplasty 1-2 teeth
D9972 External bleaching - per arch
D9973 External bleaching - per tooth
D9974 Internal bleaching - per tooth
D0310 Sialography
D0472 Oral Pathology lab
D0473 Oral Pathology lab
D0474 Oral Pathology lab
D0480 Oral Pathology lab
D0502 Oral Pathology lab
D5911 Facial Moulage (sectional)
D5912 Facial Moulage (complete)
D5913 Nasal Prosthesis
D5914 Auricular Prosthesis
D5915 Orbital Prosthesis
D5916 Ocular Prosthesis
D5919 Facial Prosthesis
D5922 Nasal Septal Prosthesis
D5923 Ocular Prosthesis (interim)
D5924 Cranial Prosthesis
D5925 Facial Augmentation implant
D5926 Nasal Prosthesis (replacement)

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) - continued on next page

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) (cont.)
D5927 Auricular Prosthesis (replacement)
D5928 Orbital Prosthesis (replacement)
D5929 Facial Prosthesis (replacement)
D5931 Obturator Prosthesis (surgical)
D5932 Obturator Prosthesis (definitive)
D5933 Obturator Prosthesis (modification)
D5934 Mandibular resection Prosthesis w/guide flange
D5935 Mandibular resection Prosthesis w/out guide flange
D5936 Obturator Prosthesis (interim)
D5937 Trismus Appliance
D5951 Feeding Aid
D5952 Speech Aid prosthesis (pediatric)
D5953 Speech Aid prosthesis (adult)
D5954 Palatal Augmentation Prosthesis
D5955 Palatal Lift Prosthesis (definitive)
D5958 Palatal Lift Prosthesis (interim)
D5959 Palatal Lift Prosthesis (modification)
D5960 Speech Aid Prosthesis (modification)
D5982 Surgical Stent
D5983 Radiation Carrier
D5984 Radiation Shield
D5985 Radiation Cone locator
D5987 Commissure Splint
D5988 Surgical Splint
D5992 Adjust maxillofacial prosthetic appliance, by report
D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report
D7285 Biopsy of oral tissue (hard)
D7286 Biopsy of oral tissue (soft)
D7295 Harvest of bone for use in autogenous grafting procedures
D7410 Lesion up to 1.25 (benign)
D7411 Lesion greater than 1.25 (benign)
D7412 Complicated lesion (benign)
D7413 Lesion up to 1.25 (malignant)
D7414 Lesion greater than 1.25 (malignant)
D7415 Complicated lesion (malignant)
D7440 Lesion diameter up to 1.25 (malignant)
D7441 Lesion diameter greater than 1.25 (malignant)
D7460 Removal of Benign lesion up to 1.25
D7461 Removal of Benign lesion greater than 1.25
D7465 Destruction of lesion (by report)
D7490 Radical resection upper/lower
D7530 Removal of foreign body
D7540 Removal of reaction producing the foreign body

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) - continued on next page

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) (cont.)
D7550 Partial Ostectomy
D7560 Maxillary Sinusotomy
D7610 Upper open reduction
D7620 Upper closed reduction
D7630 Lower open reduction (simple)
D7640 Lower closed reduction (simple)
D7650 Open reduction (simple)
D7660 Closed reduction (simple)
D7670 Alveolus closed reduction (simple)
D7671 Alveolus open reduction (simple)
D7680 Facial bones (simple)
D7710 Upper open reduction (compound)
D7720 Upper closed reduction (compound)
D7730 Lower open reduction (compound)
D7740 Lower closed reduction (compound)
D7750 Malar and/or zygomatic arch open red.(compound)
D7760 Malar and/or zygomatic arch closed red.(compound)
D7770 Alveolus open red.(compound - stabilization of teeth)
D7771 Alveolus closed red. (compound – stabilization of teeth)
D7780 Facial bones (compound)
D7810 TMJ open reduction
D7820 TMJ closed reduction
D7830 TMJ manipulation
D7840 Condylectomy
D7850 Surgical discectomoy
D7852 Disc repair
D7854 Synovectomy
D7856 Myotomy
D7858 Joint reconstruction
D7860 Arthrotomy
D7865 Arthroplasty
D7870 Arthrocentesis
D7871 Non-Arthroscopic
D7872 Arthroscopy with or without a biopsy
D7873 Arthoscopy surgical adhesions
D7874 Arthoscopy surgical disc
D7875 Arthoscopy surgical synovectomy
D7876 Arthoscopy surgical discectomy
D7877 Arthoscopy surgical debridement
D7911 Complicated sutures up to 5 cm.
D7912 Complicated sutures greater than 5 cm.
D7920 Skin graft
D7940 Osteoplasty deformities
D7941 Osteotomy lower rami

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) - continued on next page

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) (cont.)
D7943 Osteotomy lower rami with bone graft
D7944 Osteotomy segmented
D7945 Osteotomy body of mandible
D7946 Lefort I upper total
D7947 Lefort I upper segmented
D7948 Lefort II or Lefort III without bone graft
D7949 Lefort II or Lefort III with bone graft
D7950 Bone graft - mandible or face
D7955 Repair of Maxillofacial soft or hard tissue
D7980 Sialolithotomy
D7981 Excision of salivary gland
D7982 Sialodochoplasty
D7983 Closure of salivary fistula
D7990 Emergency tracheotomy
D7991 Coronoidectomy
D7995 Synthetic graft
D7996 Implant lower for augmentation purposes

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 US currency.
Finding an International Provider	International employees and their dependents may contact AXA Assistance USA (AXA) for referral to dental providers outside of the continental United States or may use the dentist of their choice. The process involves a plan participant calling AXA at (312) 935-9210 collect or (866) 384-2771 to find a local provider in their country. International participants will receive in-network benefit when services are performed by an out of network internationally located provider.
Filing International Claims	The plan participant will be responsible for paying the dentist and submitting the claims to MetLife for reimbursement at the following address. Mail completed claim form to: MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282
International Rates	There is one international region. Please see the rate table for the actual premium amount.

Section 7 General Exclusions – Things We Do Not Cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care, or treatment of a covered condition. Section 5 contains lists of excluded ADA codes categorized by type of service.**

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 (TMD);
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- State or territorial taxes on dental services performed;
- Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;
- Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- Those for which the member would have no obligation to pay in the absence of this or any similar coverage;
- Those which are for specialized procedures and techniques;
- Those performed by a dentist who is compensated by a facility for similar covered services performed for members;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;

- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Gold foil restorations;
- 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;
- 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 24 month waiting period requirement.
- Orthodontic care for dependent children age 19 and over;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal bleaching;
- Nitrous oxide;
- Oral sedation;
- Topical medicament center
- Orthodontic care for a member or spouse
- Bone grafts when done in connection with extractions, apicoetomies 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 MetLife.
- 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 MetLife.
- All out of network services listed in Section 5 are subject to the usual and customary maximum allowable fee charges as defined by MetLife. The member is responsible for all remaining charges that exceed the allowable maximum.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

To avoid delay in the payment of your claims please have your dentist submit your claims directly to MetLife for payment.

MetLife's dental providers may submit their claims directly to MetLife by accessing MetDental.com where we provide them with real-time results. However, should you wish to send in a paper claim you may download a claim form from the website federaldental.metlife.com.

Mail completed claim form to:

MetLife Dental Claims

P.O. Box 981282

El Paso, TX 79998-1282

When a claimant files a claim for dental insurance benefits described in this brochure, both the notice of claim and the required Proof should be sent to us within 90 days of the date of a loss. If notice of claim or proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible

Deadline For Filing Your Claim

You must submit your claim to us within 13 months following the delivery of the services in order for them to be considered for Plan benefits.

Disputed Claims Process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must include any pertinent information omitted from the initial claim filing and mail your additional proof to us within 180 days from the date of receipt of our decision.
2	Send your request for reconsideration to: MetLife Dental Claims Appeals P.O. Box 14589 Lexington, KY 40512 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 MetLife and OPM, review the decision. To qualify for this independent third party review the charge for the procedure in question must be in excess of $300 and the reason for denial must be based on our determination that the rationale for the procedure did not meet our dental necessity criteria or our administration of the plans Alternate Benefit provision, for example, a bridge being given an alternate benefit of a partial denture. The decision of the independent third party is binding and is the final review of your claim. This decision is not subject to judicial review. If the matter is not eligible for this third level of review, the second level of review is binding and is the final remedy available to you. This decision is not subject to judicial review.

Initial Determination

MetLife will review your claim and notify you of its decision to approve or deny your claim Such notification will be provided to you within a 30-day period from the date you submitted your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of the Plan. If MetLife needs such an extension, MetLife will notify you prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision (s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Overpayments

We have the right to recover any amount that we determine to be an overpayment, whether for services received by you or your dependents.

An overpayment occurs if we determine that:

- the total amount paid by us on a claim for dental benefits is more than the total of the benefits due to you under this brochure; or
- payment we made should have been made by another group plan

If such overpayment occurs, you have an obligation to reimburse us.

Recovery of Dental Insurance Overpayments

We may recover the overpayment from you by: stopping or reducing any future benefits payable under the MetLife Federal Dental Plan; demanding an immediate refund of the overpayment from you; and/or taking legal action.

We may recover such overpayment in accordance with that agreement. If the overpayment results from MetLife having made a payment to you that should have been made under another group plan, we may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or

If such payment occurs, you have an obligation to reimburse us any monies you have received over and above what your normal out of pocket would have been had the overpayment not occurred.

HIPAA Privacy Practices

This section describes how medical information about you may be used and disclosed and how you can get information. Please review this section carefully.

MetLife and each member of the MetLife family of companies (an Affiliate") strongly believe in protecting the confidentiality and security of information we collect about you. This section refers to MetLife by using the terms "us," "we," or "our."

This section describes how we protect the personal health information we have about you which relates to your coverage under the MetLife Federal Dental Plan ("Personal Health Information"), and how we may use and disclose this information. Personal Health Information includes individually identifiable information, which relates to your past, present or future health, treatment or payment for health care services. This section also describes your rights with respect to the Personal Health Information and how you can exercise those rights.

We are required to provide notice of our privacy practices for Personal Health Information to you by the Health Insurance Portability and Accountability Act ("HIPAA"). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please see the privacy notices contained at our website, www.metlife.com. You may submit questions to us there or you may write to us directly at MetLife, Institutional Business HIPAA Privacy Office, P.O. Box 6898 Bridgewater, New Jersey 08807-6896. We are required by law to:

- maintain the privacy of your Personal Health Information;
- provide you notice of our legal duties and privacy practices with respect to your Personal Health Information; and
- follow the terms of our HIPAA privacy practices as explained in this section.

We protect your Personal Health Information from inappropriate use or disclosure. Our employees, and those of companies that help us service your insurance coverage under the MetLife Federal Dental Plan, are required to comply with our requirements that protect the confidentiality of Personal Health Information. They may look at your Personal Health Information only when there is an appropriate reason to do so, such as to administer our products or services.

We will not disclose your Personal Health Information to any other company for their use in marketing their products to you. However, as described below, we will use and disclose Personal Health Information about you for business purposes relating to your Dental Insurance coverage.

The main reasons for which we may use and may disclose your Personal Health Information are to evaluate and process any requests for coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The following describe these and other uses and disclosures, together with some examples.

For Payment:

We may use and disclose Personal Health Information to pay for benefits under the MetLife Federal Dental Plan. For example, we may review Personal Health Information contained on claims to reimburse providers for services rendered. We may also disclose Personal Health Information to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose Personal Health Information to a health plan or an administrator of an employee welfare benefit plan for various payment related functions, such as eligibility determination, audit and review or to assist you with your inquiries or disputes.

For Health Care Operations	We may also use and disclose Personal Health Information for our insurance operations. These purposes include evaluating a request for dental insurance products or services, administering those products or services, and processing transactions requested by you. We may also disclose Personal Health Information to Affiliates, and to business associates outside of the MetLife family of companies, if they need to receive Personal Health Information to provide a service to us and will agreed to abide by specific HIPAA rules relating to the protection of Personal Health Information. Examples of business associates are: billing companies, data processing companies, or companies that provide general administrative services. Personal Health Information may be disclosed to reinsurers for underwriting, audit or claim review reasons. Personal Health Information may also be disclosed as part of a potential merger or acquisition involving our business in order to make an informed business decision regarding any such prospective transaction.
Where Required by Law or for Public Health Activities	We disclose Personal Health Information when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing Personal Health Information to a governmental agency or regulator with health care oversight responsibilities. We may also release Personal Health Information to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.
To Avert a Serious Threat to Health or Safety	We may disclose Personal Health Information to avert a serious threat to someone's health or safety. We may also disclose Personal Health Information to federal, state or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.
For Health-Related Benefits or Services	We may use Personal Health Information to provide you with information about benefits available to you under your current coverage and, in limited situations, about health-related products or services that may be of interest to you.
For Law Enforcement or Specific Government Functions	We may disclose Personal Health Information in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose Personal Health Information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
When Requested as Part of a Regulatory or Legal Proceeding	If you or your estate is involved in a lawsuit or a dispute, we may disclose Personal Health Information about you in response to a court or administrative order. We may also disclose Personal Health Information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the Personal Health Information requested. We may disclose Personal Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.
Other Uses of Personal Health Information	Other uses and disclosures of Personal Health Information not covered by this section and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose Personal Health Information about you, you or your legally authorized representative may revoke that authorization, in writing, at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your dental insurance coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.
Your Rights Regarding Personal Health Information We Maintain About You	The following are your various rights as a consumer under HIPAA concerning your Personal Health Information. Should you have questions about a specific right, please write to us at the location listed in our discussion of that right.

Right to Inspect and Copy Your Personal Health Information

In most cases, you have the right to inspect and obtain a copy of the Personal Health Information that we maintain about you. To inspect and copy Personal Health Information, you must submit your request in writing to MetLife P.O. Box 14587, Lexington, KY 40512. To receive a copy of your Personal Health Information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of Personal Health Information will not be made available for inspection and copying. This includes Personal Health Information collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances, we may deny your request to inspect and obtain a copy of your Personal Health Information. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

Right to Amend Your Personal Health Information

If you believe that your Personal Health Information is incorrect or that an important part of it is missing, you have the right to ask us to amend your Personal Health Information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to MetLife P.O. Box 14587, Lexington, KY 40512. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend Personal Health Information that:

- is accurate and complete;
- was not created by us, unless the person or entity that created the Personal Health Information is no longer available to make the amendment;
- is not part of the Personal Health Information kept by or for us; or
- is not part of the Personal Health Information, which you would be permitted to inspect and copy.

Right to a List of Disclosures

You have the right to request a list of the disclosures we have made of Personal Health Information about you. This list will not include disclosures made for treatment, payment, health care operations, for purposes of national security, made to law enforcement or to corrections personnel or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to MetLife P.O. Box 14587, Lexington, KY 40512. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before February 26, 2003. Your request should indicate in what form you want the list (For example, on paper or electronically). The first list you request within a 12 month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on Personal Health Information we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing to MetLife P.O. Box 14587, Lexington, KY 40512. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (For example, disclosures to your spouse or parent). We will not agree to restrictions on Personal Health Information uses or disclosures that are legally required, or which are necessary to administer our business.

Right to Request Confidential Communications

You have the right to request that we communicate with you about Personal Health Information in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example,,, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to MetLife P.O. Box 14587, Lexington, KY 40512 and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to File a Complaint

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact MetLife, Institutional Business HIPAA Privacy Office, P.O. Box 6896 Bridgewater NJ 08807-6896. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions as how to file a complaint please contact us at (908) 253-2706 or at HIPAAprivacyInst@MetLife.com.

Additional Information

Changes to Our HIPAA Privacy Practices

We reserve the right to change the terms of our HIPAA privacy practices for Personal Health Information at any time. We reserve the right to make the revised or changed practices effective for Personal Health Information we already have about you as well as any Personal Health Information we receive in the future. You will receive a copy of any revised notice from MetLife by mail or by e-mail, but only if e-mail delivery is offered by MetLife and you agree to such delivery.

Further Information

You may have additional rights under other applicable laws. For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies please contact us at HIPAAprivacyInst@MetLife.com, (908) 253-2706 or write to us at MetLife, Institutional Business HIPAA Privacy Office, P.O. Box 6898 Bridgewater, New Jersey 08807-6896.

Section 9 Definitions of Terms We Use in This Brochure

Alternate Benefit	If we determine a service less costly than the one preformed 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, 2012 through December 31, 2012. Also referred to as the Plan year.
Class A Services	Basic services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
Class B Services	Intermediate services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
Class C Services	Major services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
Class D Services	Orthodontic services.
Date of Service	The calendar date on which you visit the dentist's office and services are rendered.
Enrollee	The Federal employee 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.
Maximum Allowed 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 MetLife has negotiated with the provider and they have agreed to accept as payment in full for his/her services.
Plan	The MetLife Federal Dental Plan
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 MetLife's determination of usual and customary charges for the procedure or procedures.

Usual and Customary Charge

Usual and Customary Charges are the lowest of:

- the Dentist's actual charge for the services or supplies (or, if the provider of the service or supplies is not a Dentist, such other provider's actual charge for the services or supplies); or
- the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies; or
- the usual allowance for an area is the usual charge made by most dentists in the same geographic area for the same or similar service or supply. MetLife's claim payment system uses data accumulated through internal claim processing to establish procedure code specific customary allowance within a geographic area. We use the 80th percentile charge to establish a customary allowance. Using the 80th percentile recognizes that even within a geographically contiguous area, charges for a procedure may vary based on location, provider qualifications, or the nature of the specific case. At the same time, payment for charges far in excess of the prevailing fee will be reduced to the 80th percentile amount for benefit payment purposes. The 80th percentile is felt to be a fair level since full payment is allowed not only for average charges, but also for fees somewhat about the average rate.
- **An example,** of how the 80th percentile is calculated is to assume one hundred (100) charges for the same service are contained in MetLife's Usual and Customary charge records. These one hundred (100) charges would be sorted from lowest to highest charged amount and numbered 1 through 100. The 80th percentile of charges is the charge that is greater than or equal to the charged numbered 80.

Waiting Period

The amount of time that you must be enrolled in this Plan before you can receive orthodontic services. Benefits are prorated if the treatment began prior to satisfying the waiting period. Please see Section 4 How You Obtain Care, for an explanation of how the benefits will be prorated

We/Us

The MetLife Federal Dental Plan

You/Your

Enrollee or eligible family member.

Summary of Benefits

- **Do not rely on this chart alone.** This page summarizes your portion of the expenses we cover; please review the individual sections of this brochure, for more detail.
- If you want to enroll or change your enrollment in this plan, please visit www.BENEFEDS.com or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680.
- Out-of-Network services under Classes A, B and C are subject to a deductible of $50 for the High Option or $100 for the Standard Option per calendar year.

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

	You Pay	
Standard Option Benefits	**In-network**	**Out-of-network**
Class A (Basic) Services – preventive and diagnostic	0%	40%
Class B (Intermediate) Services – includes minor restorative services	45%	60%
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	65%	80%
Class A, B, and C Services are subject to a $1,200 annual maximum benefit for the In-network benefits and $600 for the Out of network benefits		
Class D Services – orthodontic $1,500 Lifetime Maximum for the In-network Or a $1,000 Lifetime Maxim for the Out-of- network	50%	50%

Stop Health Care Fraud!

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, the MetLife Federal Dental Plan, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your explanation of benefits (EOBs) statements.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at (888) 865-6854 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 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.

Rate Information for 2012

1. ***How to find your monthly rate***

- In the first chart below, look up your state or zip code to determine your Rating Area.
- In the second chart below, match your Rating Area to your enrollment type. The rate is the same for both High and Standard Option.

State	State/Zip (first 3)	MetLife High/ Standard Options Premium Rating Area	State	State/Zip (first 3)	MetLife High/ Standard Options Premium Rating Area
AK	entire state	5	IN	463-464	4
AL	entire state	1	IN	rest of state	1
AR	entire state	1	KS	entire state	1
AZ	entire state	1	KY	entire state	1
CA	919-921, 942,956-958	4	LA	entire state	1
CA	rest of state	5	MA	entire state	5
CO	entire state	4	MD	206-218	4
CT	entire state	5	MD	219	3
DC	entire district	4	MD	rest of state	2
DE	entire state	3	ME	entire state	2
FL	330-334	3	MI	480-485	3
FL	rest of state	1	MI	rest of state	2
GA	300-303, 311	2	MN	550-555	4
GA	rest of state	1	MN	rest of state	2
HI	entire state	4	MO	entire state	1
IA	entire state	1	MS	entire state	1
ID	entire state	1	MT	entire state	1
IL	600-608	4	NC	entire state	1
IL	rest of state	1	ND	entire state	1

State	State/Zip (first 3)	MetLife High/ Standard Options Premium Rating Area	State	State/Zip (first 3)	MetLife High/ Standard Options Premium Rating Area
NE	entire state	1	RI	entire state	5
NH	entire state	5	SC	entire state	1
NJ	080-084	3	SD	entire state	1
NJ	rest of state	5	TN	entire state	1
NM	entire state	1	TX	entire state	1
NV	897	4	UT	entire state	1
NV	rest of state	2	VA	201, 220-226	4
NY	004, 005,100-119,124-126	5	VA	rest of state	1
NY	rest of state	2	VT	entire state	2
OH	entire state	1	WA	980-985	5
OK	entire state	1	WA	rest of state	4
OR	970-973	4	WI	540	4
OR	rest of state	3	WI	rest of state	2
PA	183	5	WV	entire state	1
PA	189-194	3	WY	entire state	1
PA	rest of state	1	VI	All	0
PR	All	1	GU	All	0
			INTERNATIONAL	All	0

2012 Monthly Rate Information for The MetLife Federal Dental Program

Monthly Rates

How to find your monthly rate

- In the chart below, look up your state or zip code to determine your Rating Area.

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	$33.95	$ 67.88	$101.75	$18.48	$37.01	$55.53
2	$37.96	$75.99	$113.95	$20.00	$39.98	$60.02
3	$41.38	$82.66	$124.04	$22.14	$44.24	$66.39
4	$44.76	$89.46	$134.20	$24.59	$49.18	$73.75
5	$50.12	$100.21	$150.30	$27.00	$53.99	$81.01
International	$50.12	$100.21	$150.30	$27.00	$53.99	$81.01

How to find your bi-weekly rate

- In the chart below, look up your state or zip code to determine your Rating Area.

2012 Bi-weekly Rates

Rating Areas	High option Self Only	High option Self Plus One	High Option Self andFamily	Standard option Self Only	Standard option Self Plus One	Standard option Self and Family
1	$15.67	$31.33	$46.96	$8.53	$17.08	$25.63
2	$17.52	$35.07	$52.59	$9.23	$18.45	$27.70
3	$19.10	$38.15	$57.25	$10.22	$20.42	$30.64
4	$20.66	$41.29	$61.94	$11.35	$22.70	$34.04
5	$23.13	$46.25	$69.37	$12.46	$24.92	$37.39
International	$23.13	$46.25	$69.37	$12.46	$24.92	$37.39

FEP BlueVision®

http://www.fepblue.org

BlueCross BlueShield
Federal Employee Program
FEP BlueVision®

2012

A Nationwide Vision 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 the 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**

The FEP BlueVision credentialing process was constructed to meet and exceed NCQA requirements.

The FEP BlueVision fabrication system has received full certification from the COLTS Laboratories "Quality First" program, a leading, independent ophthalmic testing organization.

The FEP BlueVision laboratories have ISO 9001:2008 certification. The International Organization for Standardization with ISO 9000 is the international reference for quality management requirements.

FEDVIP
Federal Employees
Dental and Vision Insurance Program

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The 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 FEP BlueVision under the Blue Cross and Blue Shield Association's contract OPM-06-00060-2 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

FEP BlueVision
711 Troy Schenectady Road, Suite 301
Latham, New York 12110
1-888-550-BLUE (2583)
www.fepblue.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. You, and your family members, do not have a right to benefits that were available before January 1, 2012 unless those benefits are also shown in this brochure.

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated eligible family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits.

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

FEP BlueVision is responsible for the selection of in-network providers in your area. Contact us at 1-888-550-2583 for the names of participating providers or to request a provider directory. You may also request or view the most current directory via our website at **www.fepblue.org**. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not on a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in-network. If your provider is not currently participating in the provider network, you can nominate him or her to join. Nomination forms are available on our web site, or call us and we will take your nomination over the phone. You cannot change plans, outside of Open Season, because of changes to the provider network.

Provider networks may be more extensive in some areas than others. **Please be aware that the FEP BlueVision network is different from the network of your health plan.**

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

We want you to know that protecting the confidentiality of your individually identifiable health information is of the utmost importance to us. To review full details about our privacy practices, our legal duties, and your rights, please visit our website, www.fepblue.org and click on the link to FEP BlueVision, and then click on the "Privacy Policies" link at the bottom of the page. If you do not have access to the internet or would like further information, please contact us by calling 1-888-550-2583.

Table of Contents

How We Have Changed for 2012

Under High Option, the $65 copay for plastic photosensitive lenses (Transitions®) has been eliminated.

Eligible FSAFEDS expenses may be automatically submitted electronically through paperless reimbursement.

FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas regional, dental Preferred Provider Organizations (PPO), 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/insure/dental or www.opm.gov/insure/vision for more information.
Enroll Through BENEFEDS	You enroll through the Internet 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) can not 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 2011 Open Season, your coverage will begin on January 1, 2012. Premium deductions will start with the first full pay period beginning on/after January 1, 2012. 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, 2011 through December 12, 2011. 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.

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. Enrollment in the FEHB Program 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.

Advise BENEFEDS of your new payroll office number.

Survivor Annuitants

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

Compensationers

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

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 www.opm.gov/insure/dental or www.opm.gov/insure/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 or options, your enrollment will continue automatically. Please note: your plans' premiums may change for 2012.

Note: You cannot enroll 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 through December 12, 2011 Open Season. Coverage is effective January 1, 2012.

During future annual Open Seasons, you may enroll in a plan, or change or cancel your dental and/or vision coverage. The effective date of these Open Season enrollments and changes will be set by OPM. If you want to continue your current enrollment, do nothing. **Your enrollment carries over from year to year, unless you change it.**

New hire/Newly eligible

You may enroll within 60 days after you become eligible as:

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

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
Acquiring an eligible family member	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-pay status (enrollee and spouse)	No	No	No	Yes	No
Returning to pay status from active military duty (enrollee and spouse)	Yes	No	No	No	No
Annuity/ compensation restored	Yes	Yes	Yes	No	No
Transferring to an eligible Federal 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 a 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 a dental or a vision plan, you cannot change or cancel that particular enrollment until the next Open Season, unless you experience a QLE that allows such a change or cancellation.

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.

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.

Current FSAFEDS participants must re-enroll to participate in 2012. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-800-952-0450.

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you may use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB and FEDVIP plans.

Using your FSA pre-tax dollars for your eyecare and eyewear needs is a great way to get more out of your benefit dollar. And FEP BlueVision will submit your eligible FSAFEDS out-of-pocket expenses electronically, so you don't have to.

Using your FSAFEDS account for your eyecare and eyewear expenses is simple:

- Visit your provider for your routine eye examination and eyewear
- Pay any out-of-pocket expenses
- FEP BlueVision will submit your expenses for reimbursement for you.

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation

Two ID cards are issued for each member, regardless of coverage option. If additional cards are needed, you may request them through our website, www.fepblue.org or call us at 1-888-550-2583. All eligible dependents listed on your enrollment share your identification number. You do not need an ID card for each member of your family.

Plan Providers

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

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

In-Network

In-network providers are referred to as participating providers. The FEP BlueVision in-network benefit is paperless and extremely user-friendly for members. When scheduling an appointment, you should identify yourself as a member of FEP BlueVision and provide your name and identification number. The provider is then responsible for verifying eligibility by contacting FEP BlueVision either by telephone or via the web.

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

Out-of-Network

Out-of-network providers are referred to as non-participating providers. High Option: We will provide fee schedule allowances as described in Section 4, Your Cost For Covered Services, for covered services performed by non-participating providers. However, since these providers do not participate with FEP BlueVision, you may be responsible for any amounts over the fee schedule allowances. Please see Section 8, Claims Filing and Disputed Claims Processes, for information.

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

Pre-Authorization

Pre-authorization is only required for:

- Medically necessary contact lenses in the treatment of certain eye health conditions and is obtained by the participating provider.
- The treatment of low vision and is obtained by the participating provider.
- Discounts for laser vision correction and is obtained by the member.

First Payor

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.

Coordination of Benefits

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

Limited Access Areas

If you live in an area that does not have adequate access to an FEP BlueVision network provider and you receive covered services from an out-of-network provider, we will pay up to 100% of our Plan Allowance. You are responsible for any difference between the amount billed and our payment. To determine if you are in a limited access area call us at 1-888-550-2583. Please see Section 4, Your Cost for Covered Services, for more information. Please see Section 8, Claims Filing and Disputed Claims Processes, for information.

Section 4 Your Cost for Covered Services

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

Copayment

There are no copayments for covered eye examinations, standard eyeglass lenses, plan frames, or contact lenses in lieu of eyeglasses. There may be copayments for optional lens types and treatments.

Annual Benefit Maximum

- Standard Option: one routine eye examination every calendar year; one pair of standard eyeglass lenses or contact lenses every calendar year; one frame every other calendar year. (Contact lens benefit available in lieu of eyeglasses.)
- High Option: one routine eye examination every calendar year; one pair of standard eyeglass lenses or contact lenses every calendar year; one frame every calendar year. (Contact lens benefit available in lieu of eyeglasses.)

In-Network Services

Members are only responsible for any cost that exceeds the Plan Allowances (as described in Section 5, Vision Services and Supplies) and copayments for optional lenses and treatments (as described in Section 5, Vision Services and Supplies). To receive covered benefits, you must stay in-network if you are enrolled in Standard Option.

Out-of-Network Services

If you are enrolled in Standard Option, you must stay in-network for covered services. If you receive care from a non-participating provider, we will not pay for any services unless you reside in a limited access area.

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

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

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

Limited Access Areas

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

***NOTE: Access Standards**

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

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

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

Services/Materials	**Standard Option** **We Pay**	**High Option** **We Pay**
Exam	Up to $50	Up to $50
Single Vision Lenses	Up to $72	Up to $72
Bifocal Lenses	Up to $109	Up to $109
Trifocal Lenses	Up to $136	Up to $136
Lenticular Lenses	Up to $136	Up to $136
Contact Lenses	Up to $130	Up to $150
Medically Necessary Contact Lenses	Up to $600	Up to $600
Frames	Up to $130	Up to $150

Section 5 Vision Services and Supplies

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted protocols.

Benefit Description	You Pay	
Diagnostic	**Standard Option**	**High Option**
Eye exam: covered in full every calendar year. Includes dilation, if professionally indicated. 92002/92004 New patient exams 92012/92014 Established patient exams S0620 Routine ophthalmologic exam w/refraction - new patient S0621 Routine ophthalmologic exam w/refraction - established patient	In-Network: Nothing Out-of-Network: All charges	In-Network: Nothing Out-of-Network: Expenses in excess of the fee schedule allowance of $30
Eyewear	**Standard Option**	**High Option**
You may choose prescription glasses or contacts.		
Lenses: one pair covered in full every calendar year. V2100-2199 Single Vision V2200-2299 Conventional (Lined) Bifocal V2300-2399 Conventional (Lined) Trifocal V2121, V2221, V2321 Lenticular Note: Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses. Note: Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions ≥ +/- 6.00 diopters. Note: All lenses include scratch resistant coating with no additional copayment. There may be an additional charge at Walmart and Sam's Club.	In-Network: Nothing Out-of-Network: All charges	In-Network: Nothing Out-of-Network: Expenses in excess of fee schedule allowance of: $25 single vision $35 lined bifocal $45 lined trifocal $45 lenticular
Frame: *High Option:* covered once every calendar year. *Standard Option:* covered once every other calendar year. V2020 Frame *Note: Additional discounts are available from participating providers except Walmart and Sam's Club.	In-Network: Collection Frame: Nothing Non-Collection Frame: Expenses in excess of a $130 allowance. Additionally, a 20% discount applies to any amount over $130* Out-of-Network: All charges	In-Network: Collection Frame: Nothing Non-Collection Frame: Expenses in excess of a $150 allowance. Additionally, a 20% discount applies to any amount over $150* Out-of-Network: Expenses in excess of fee schedule allowance of $30

Eyewear - continued on next page

Benefit Description	You Pay	
Eyewear (cont.)	**Standard Option**	**High Option**
Note: Your eyewear will be delivered to your provider from the FEP BlueVision laboratory generally within two to five business days. More delivery time may be needed when out-of-stock frames, AR (anti-reflective) Coating, specialized prescriptions or a non-collection frame is selected. Note: "Collection" frames with retail values up to $225 are available at no cost at most participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	In-Network: Collection Frame: Nothing Non-Collection Frame: Expenses in excess of a $130 allowance. Additionally, a 20% discount applies to any amount over $130* Out-of-Network: All charges	In-Network: Collection Frame: Nothing Non-Collection Frame: Expenses in excess of a $150 allowance. Additionally, a 20% discount applies to any amount over $150* Out-of-Network: Expenses in excess of fee schedule allowance of $30
Contact Lenses	**Standard Option**	**High Option**
Contact Lenses: covered once every calendar year – in lieu of eyeglasses. V2500-V2599 Contact Lenses Note: In some instances, participating providers may charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the Contact Lenses received is less than the allowance, you may submit a claim for the remaining balance (the combined reimbursement will not exceed the total allowance). *Note: Additional discounts are available from participating providers except Walmart and Sam's Club. **Note: Pre-authorization is required.	In-Network: Expenses in excess of a $130 allowance (may be applied toward the cost of evaluation, materials, fitting and follow-up care). Additionally, a 15% discount applies to any amount over $130.* Expenses in excess of $600 for medically necessary contact lenses.** Out-of-Network: All charges	In-Network: Expenses in excess of a $150 allowance (may be applied toward the cost of evaluation, materials, fitting and follow-up care). Additionally, a 15% discount applies to any amount over $150.* Expenses in excess of $600 for medically necessary contact lenses.** Out-of-Network: Expenses in excess of fee schedule allowance of: $75 elective contact lenses $225 medically necessary contact lenses
Other Vision Services	**Standard Option**	**High Option**
Optional Lenses and Treatments:	**In-Network Only**	**In-Network Only**
Ultraviolet Protective Coating	No Copay	No Copay
Polycarbonate Lenses (if not child, monocular or prescription ≥+/-6.00 diopters)	$30	$30
Blended Segment Lenses	$20	$20
Intermediate Vision Lenses	$30	$30
Standard Progressives	$50	No Copay
Premium Progressives (Varilux®, etc.)	$90	$90
Photochromic Glass Lenses	$20	$20
Plastic Photosensitive Lenses (Transitions®)	$65	No Copay
Polarized Lenses	$75	$75
Standard Anti-Reflective (AR) Coating	$35	$35
Premium AR Coating	$48	$48
Ultra AR Coating	$60	$60
Hi-Index Lenses	$55	$55

Benefit Description	You Pay	
Extra Discounts and Savings	**Standard Option**	**High Option**
Prescription glasses		
• Optional Lens Treatments (only available from FEP BlueVision providers)		
- **Progressive Lens Options:** Members may receive a discount on additional progressive lens options:		
Select Progressive Lenses	$70	$70
Ultra Progressive Lenses	$195	$195

Replacement Contact Lens Program: FEP BlueVision offers a contact lens replacement program to members. This exclusive mail order program provides you with the guaranteed lowest prices on contact lens replacement materials. Members may call 1-800-536-7123 with a current prescription.

Laser Vision Correction: FEP BlueVision members can realize substantial discounts on laser correction procedures (LASIK and PRK). Members are entitled to savings of up to 25% off the provider's usual and customary fees, or a 5% discount on any advertised special, from participating physicians and affiliated laser centers. (Some centers provide a flat fee equating to these discount levels.) To insure that the discount is applied correctly, the member must obtain pre-authorization for this service.

Contact us at 1-888-550-2583 for the names of participating providers and to receive a pre-authorization number.

Additional Benefits

Medically Necessary Contact Lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:

Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear. Participating providers will obtain the necessary pre-authorization for these services.

Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. After pre-authorization by FEP BlueVision, covered low vision services (both in- and out-of-network) will include one comprehensive low vision evaluation every 5 years, with a maximum charge of $300; maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period, with a maximum charge of $100 each visit. Participating providers will obtain the necessary pre-authorization for these services.

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

Section 6 International Services and Supplies

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

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

International Claims Payment

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

Finding an International Provider

We do not maintain a network of providers outside the United States and Puerto Rico. You may visit any international provider of your choice.

Filing International Claims

International providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** Claim forms are available at www.fepblue.org. To file a claim for covered vision care services received outside the United States and Puerto Rico, send completed claim forms and itemized bills to:

FEP BlueVision

P.O. Box 2010

Latham, New York 12110-2010

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

Customer Service Website and Phone Numbers

www.fepblue.org or 1-888-550-2583 or call collect 1-518-220-2583.

Laser Vision Correction

The discount on laser correction procedures (LASIK and PRK) is only available through network providers. Therefore, the discount on these procedures is not available for services received overseas.

International Plan Allowances

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

Services/Materials	We Pay	We Pay
	Standard Option	High Option
Exam	Up to $60	Up to $60
Single Vision Lenses	Up to $72	Up to $72
Bifocal Lenses	Up to $109	Up to $109
Trifocal Lenses	Up to $136	Up to $136
Lenticular Lenses	Up to $136	Up to $136
Contact Lenses	Up to $130	Up to $150
Medically Necessary Contact Lenses	Up to $600	Up to $600
Frames	Up to $130	Up to $150

Section 7 General Exclusions – Things We Do Not Cover

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

We do not cover the following:

- Services provided by non-participating providers for Standard Option members;
- Any vision service, treatment or materials not specifically listed as a covered service;
- Services and materials that are experimental or investigational;
- Services or materials which are rendered prior to your effective date;
- Services and materials incurred after the termination date of your coverage unless otherwise indicated;
- Services and materials not meeting accepted standards of optometric practice;
- Services and materials resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services or materials provided as a result of intentionally self-inflicted injury or illness;
- Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- State or territorial taxes on vision services performed;
- Medical treatment of eye disease or injury;
- Visual therapy;
- Special lens designs or coatings other than those described in this brochure;
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals;
- Services not performed by licensed personnel;
- Prosthetic devices and services;
- Insurance of contact lenses;
- Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

If your vision care provider is in the participating network, he or she will file the claim for you, and payment will be sent directly to the vision care provider.

If you live in a limited access area, overseas or if you obtain services from a non-participating provider (High Option only), you are responsible for filing the claim. You can obtain claim forms at www.fepblue.org or call 1-888-550-2583.

After services have been received, submit an out-of-network claim form along with copies of the provider's bills to:

FEP BlueVision

P.O. Box 2010

Latham, New York 12110-2010

Deadline for Filing Your Claim

Participating providers will file your claim for you.

For international claims, those incurred in limited access areas and out-of-network claims*, the standard time limit for filing a claim is up to one year from the date of service.

* High Option Only

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. The provider, member or patient may appeal any decision to deny services before, during or after the service is provided. Ask us in writing to reconsider our initial decision. You must send written notice of disputed claims via U.S. Mail to:

Quality Assurance/Patient Advocate Department

FEP BlueVision

P.O. Box 791

Latham, New York 12110-0791

2. We will acknowledge receipt of your request within five business days from the date we receive it and will give you a decision within 30 days.

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

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

Section 9 Definitions of Terms We Use in This Brochure

Annual Benefit Maximum	The maximum annual benefit that you can receive, per person, under this plan.
Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Enrollee	The Federal employee or annuitant enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Plan Allowance	The maximum benefit payment for services received. Please refer to Section 4, Your Cost for Covered Services, for the maximum benefit payment for services received in limited access areas or out-of-network and Section 6, International Services and Supplies, for services received outside the United States or Puerto Rico.
Pre-Authorization	This is the procedure used by the plan to pre-approve services and the amount that the plan will cover.
We/Us	FEP BlueVision.
You	Enrollee or eligible family member.

Stop Health Care Fraud!

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, plan, BENEFEDS or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-888-550-BLUE (2583) and explain the situation.
- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self-support).

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

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

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

Notes

Summary of Benefits

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

Covered Services In-Network	High Option You Pay	Standard Option You Pay	Page
Routine Eye Exams (including dilation, if professionally indicated)	Nothing	Nothing	12
Standard Eyeglass Lenses (Contact lenses may be obtained in lieu of glasses) Optional Lens Treatments	Nothing Some additional copays	Nothing Some additional copays	12
Frames			
Collection Frames	Nothing	Nothing	12-13
Non-Collection Frame	Any amount over the $150 Plan allowance after a 20% discount	Any amount over the $130 Plan allowance after a 20% discount	12-13
Contact Lenses	Any amount over the $150 plan allowance after a 15% discount	Any amount over the $130 plan allowance after a 15% discount	13
Laser Vision Correction	The provider's charge after the negotiated discount	The provider's charge after the negotiated discount	14

See Section 4, Your Cost for Covered Services, for the Out-of-Network benefits available under High Option.

Rate Information

These rates apply nationwide and internationally.

Monthly Rates

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
$10.29	$20.56	$30.88	$8.17	$16.29	$24.46

Bi-Weekly Rates

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
$4.75	$9.49	$14.25	$3.77	$7.52	$11.29