Humana/CompBenefits

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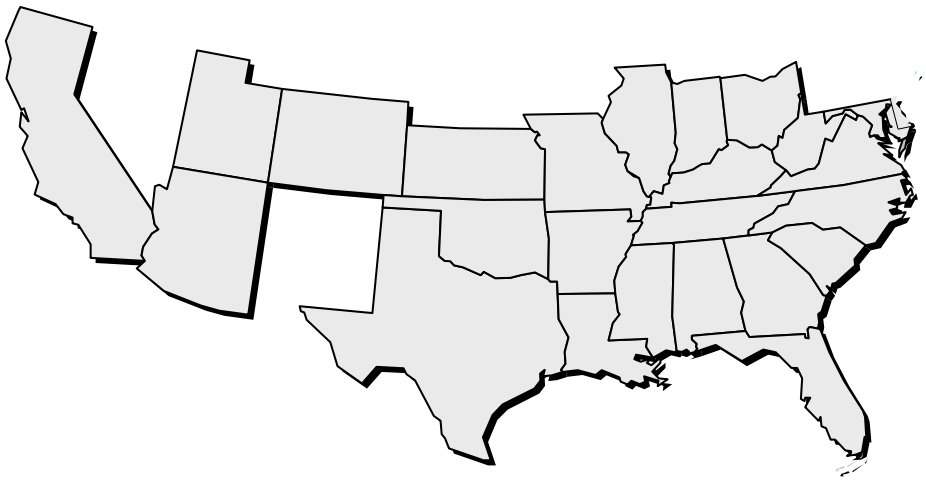
2010

HUMANA
CompBenefits

A Regional Copay Based Network Dental Plan

Serving: Alabama, Arizona, Arkansas, California, Colorado, District of Columbia, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, parts of Maryland, Missouri, Mississippi, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas, Utah, Virginia and West Virginia



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

Options:

High Option Self Only
High Option Self Plus One
High Option Self and Family

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 Advantage under Humana/CompBenefits Dental Advantage contract OPM-06-0060-3 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

Humana/CompBenefits Dental Advantage

PO Box 769179

Roswell, GA 30076-8216

1-877-692-2468

http://www.mycbfed.com/

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your benefits. You and your family members do not have a right to benefits that were available before January 1, 2010 unless those benefits are also shown in this brochure.

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

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

Humana/CompBenefits is responsible for the selection of in-network providers in your area. Contact us at 1-877-692-2468 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 www.mycbfed.com. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not for a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in-network. If your provider is not currently participating in the provider network, you may nominate him or her to join. Nomination forms are available on our website at www.mycbfed.com or call us and we will have a form sent to you. You cannot change plans, outside of Open Season, because of changes to the provider network.

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

The Humana/CompBenfits Dental Advantage Plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program.

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FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas regional, dental Preferred Provider 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 and 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 2009 Open Season, your coverage will begin on January 1, 2010. Premium deductions will start with the first full pay period beginning on/after January 1, 2010. 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 9, 2009 through December 14, 2009. 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	There is no waiting period associated with this plan.

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.

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 the same. For more information on family member eligibility, see the FEHB Handbook at www.opm.gov/insure/handbook 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 plans' premiums may change for 2010.

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 9, through December 14, 2009, Open Season. Coverage is effective January 1, 2010.

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 new 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 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 *	No	No	No	Yes	No
Return to pay status from active military duty	Yes	No	No	No	No
Annuity/compensation restored	Yes	Yes	Yes	No	No

*This also applies when your spouse goes on active duty and, as a result, you and your dependents are covered under the active military health/dental plans.

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

Canceling an enrollment

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

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

When Coverage Stops

Coverage ends when you:

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

Coverage for a family member ends when:

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

Continuation of Coverage

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

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

FSAFEDS/High Deductible Health Plans and FEDVIP

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

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 2009. 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 claims on behalf of the Humana/CompBenefits Dental Advantage Plan to the FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA) to claim reimbursement.

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation

We will send you an identification (ID) card within 15 days of your effective date. You should carry your ID card with you at all times. You should present your ID card whenever you receive services from a plan provider.

If you do not receive your ID card within 30 days after the effective date of your enrollment or if you need replacement cards, you may request one through our website at www.mycompbenefits.com or call us at 1-877-692-2468.

Where You Get Covered Care

Members should receive services from in-network providers. There is no coverage for services rendered by an out-of-network provider, with the exception of emergency services. You can find in-network providers by visiting our website: www.mycbfed.com or www.mycompbenefits.com

Plan Providers

We list plan providers in the provider directory, which we update periodically. The list is on our website at: www.mycbfed.com or www.mycompbenefits.com.

In-Network

You may see any network general dentist or specialist (e.g. Endodontist, Periodontist, etc.). You do not need a referral to see a specialist.

Out-of-Network

There are no out-of-network benefits available except for emergency care.

Emergency Services

If you have an emergency outside of the service area, visit any general dentist or specialist for care. We will reimburse you for emergency services up to $100 per member per year.

Coordination of Benefits

If you have dental or vision coverage through your FEHB plan and coverage under FEDVIP, your FEHB plan will be the first payor of any benefit payments. We are responsible for coordinating benefits with the primary payor.

We will also coordinate benefit payments with the payment of benefits under other group health benefits coverage you may have and the payment of dental costs under no-fault insurance that pays benefits without regard to fault.

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

Note: Should your dentist be a participating in network provider for both the FEHB and the FEDVIP plan, he may charge you up to the higher of the two contracted fees. If the combined payment of both plans is less then the higher contracted amount, you maybe asked to pay the difference.

Service Area

To enroll in this plan, you must live in our service area. This is where our providers practice. Our service area is: Alabama, Arkansas, Arizona, California, Colorado, District of Columbia, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, parts of Maryland, Missouri, Mississippi, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas, Utah, Virginia, and West Virginia.

Ordinarily, you must get your care from providers within the service area who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. An emergency is treatment due to injury, accident or severe pain requiring the services of a dentist which occurs under circumstances where it is neither medically or physically possible for you to be treated by a plan provider. We will not pay for any other services out of our service area unless the services have prior plan approval.

If you move outside of our service area, you may enroll in another plan at that time. You do not have to wait until Open Season to change plans. Contact BENEFEDS at www.BENEFEDS.com or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to change plans.

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.
Limited Access Areas	If you live in a limited access area and you receive covered services from an out-of-network provider, we will pay in accordance with our plan allowance. You are responsible for any difference between the amount billed and our payment. You can find a list of our limited access areas by contacting us at 1-877-692-2468.
Alternate Benefit	There are no alternate benefits associated with this plan. The copayment for each listed procedure you receive is the total amount you will owe the dentist.
Dental Review	Claims submitted by dentists that may be for cosmetic purposes only are subject to dental review prior to payment.

Section 4 Your Cost for Covered Services

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

Co-payment	A co-payment is a fixed amount of money you pay directly to the dentist when you receive covered services. Your benefit schedule lists the co-payments for each covered procedure. There are no additional charges. Example: In our plan, you pay $29 for an amalgam – one surface primary or permanent.
Annual Benefit Maximum	The annual benefit maximum under this plan is $10,000. Once you reach this amount, you are responsible for all charges.
Lifetime Benefit Maximum	There is no lifetime benefit maximum under this plan
In-Network Services	The co-payment amounts listed in the benefit schedule represent your total cost for in-network services.
Out-of-Network Services	Benefits under your plan must be received through in-network dentists. There is no coverage for services rendered by an out-of-network provider.
Emergency Services	An emergency is treatment due to injury, accident or severe pain requiring the services of a dentist which occurs under circumstances where it is neither medically or physically possible for you to be treated by a plan provider. We will not pay for any other services out of our service area unless the services have prior plan approval. We will reimburse you up to $100 per member per year. When traveling overseas, we will authorize emergency services only.
Plan Allowance	The amounts we pay to the providers are the plan allowances. The co-payments in Section 5 are the only payments you make to the dentist for covered services. There are no calculations based on plan allowances that will result in any additional costs to you.

Section 5 Dental Services And Supplies
Class A Basic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- There is no waiting period for basic services.
- The annual benefit maximum is $10,000.

You Pay:

- ***High Option***
  - **In-Network:** The co-pay amount shown in the Benefit Schedule.
  - **Out-of-Network: In full for all charges.** There are no out-of-network benefits available except for emergency services when the services of an in-network provider are not available.

Diagnostic and Treatment Services

	Co-Pay Amount
D0120 Periodic oral evaluation - *Limited to twice every 12 months*	$0
D0140 Limited oral evaluation - problem focused - *Limited to once every 12 months*	$0
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver – *Limited to once per patient per lifetime*	$0
D0150 Comprehensive oral evaluation - *Limited to once every 12 months*	$0
D0180 Comprehensive periodontal evaluation –*Limited to once every 12 months*	$0
D0210 Intraoral - complete series (including bitewings) – *Limited to once every 3 years*	$0
D0220 Intraoral - periapical first film	$0
D0230 Intraoral - periapical - each additional film	$0
D0240 Intraoral - occlusal film	$0
D0270 Bitewing - single film – *Limited to twice every 12 months*	$0
D0272 Bitewings - two films – *Limited to twice every 12 months*	$0
D0273 Bitewings – three films – *Limited to twice every 12 months*	$0
D0274 Bitewings - four films – *Limited to twice every 12 months*	$0
D0277 Vertical bitewings – 7 to 8 films – *Limited to 2 every 12 months*	$0
D0330 Panoramic film – *Limited to once every 3 years*	$0
D0425 Caries susceptibility tests	$0

Preventative Services

	Co-Pay Amount
D1110 Prophylaxis – adult - *Limited to twice every 12 months*	$0
D1120 Prophylaxis – child - *Limited to twice every 12 months*	$0
D1203 Topical application of fluoride (excluding prophylaxis) – child - *Limited to twice every 12 months*	$0
D1204 Topical application of fluoride (excluding prophylaxis) – adult - *Limited to twice every 12 months*	$0

D1206 Topical fluoride varnish, therapeutic application for moderate to high caries risk patients - *Limited to twice every 12 months*	$0
D1351 Sealant - per tooth - *Limited to permanent molar and children under age 18. One sealant per tooth in a 3-year period*	$0
D1510 Space maintainer - fixed – unilateral - *Limited to children under age 19*	$0
D1515 Space maintainer - fixed – bilateral - *Limited to children under age 19*	$0
D1520 Space maintainer - removable – unilateral - *Limited to children under age 19*	$0
D1525 Space maintainer - removable – bilateral - *Limited to children under age 19*	$0
D1550 Re-cementation of space maintainer - *Limited to children under age 19*	$0

Additional Procedures covered as Basic Services

D9110 Palliative treatment of dental pain – minor procedure	$0

Not covered:

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

Class B Intermediate

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- There is no waiting period for intermediate services.
- The annual benefit maximum is $10,000.

You Pay:

- ***High Option***
  - **In-Network:** The co-pay amount shown in the Schedule of Benefits.
  - **Out-of-Network: In full for all charges.** There are no out-of-network benefits available except for emergency services when the services of an in-network provider are not available.

Minor Restorative Services

	Co-Pay Amount
D2140 Amalgam - one surface, primary or permanent - *Limited to once per tooth every 24 months*	$29
D2150 Amalgam - two surfaces, primary or permanent - *Limited to once per tooth every 24 months*	$38
D2160 Amalgam – three surfaces, primary or permanent – *Limited to once per tooth every 24 months*	$46
D2161 Amalgam - four or more surfaces, primary or permanent - *Limited to once per tooth every 24 months*	$54
D2330 Resin–based composite - one surface, anterior - *Limited to once per tooth every 24 months*	$36
D2331 Resin-based composite - two surfaces, anterior - *Limited to once per tooth every 24 months*	$44
D2332 Resin-based composite - three surfaces, anterior - *Limited to once per tooth every 24 months*	$54
D2335 Resin-based composite - four or more surfaces or involving incisal angle, anterior - *Limited to once per tooth every 24 months*	$64
D2391 Resin-based composite- one surface, posterior – Limited to once per tooth every 24 months	$53
D2392 Resin-based composite – two surfaces, posterior – Limited to once per tooth every 24 months	$69
D2393 Resin-based composite – three surfaces, posterior – Limited to once per tooth every 24 months	$85
D2394 Resin-based composite – four or more surfaces, posterior – Limited to once per tooth every 24 months	$103
D2910 Recement inlay	$24
D2920 Recement crown	$24
D2930 Prefabricated stainless steel crown - primary tooth - *Limited to one, per tooth, per lifetime to age 15 or higher if as a result of accidental injury*	$67
D2931 Prefabricated stainless steel crown - permanent tooth - *Limited to one , per tooth, per lifetime to age 15 or higher if as a result of accidental injury*	$74
D2951 Pin retention - per tooth, in addition to restoration	$16

Not Covered:

- *Restorations, including veneers, which are placed for cosmetic purposes only*
- *Sedative restorations*
- *Gold foil restorations*
- *Inlays*

Endodontic Services

	Co-Pay Amount
D3220 Therapeutic pulpotomy (excluding final restoration)	$46
D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) – *up to age 11*	$53
D3240 Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) - *up to age 11*	$60

Periodontal Services

	Co-Pay Amount
D4341 Periodontal scaling and root planning-four or more teeth per quadrant – *Limited to once per quad every 24 months*	$63
D4342 Periodontal scaling and root planning-one to three teeth, per quadrant – *Limited to once per quad every 24 months*	$41
D4910 Periodontal maintenance – *Limited to twice every 12 months*	$39

Prosthodontic Services

	Co-Pay Amount
D5410 Adjust complete denture – maxillary	$22
D5411 Adjust complete denture – mandibular	$22
D5421 Adjust partial denture – maxillary	$22
D5422 Adjust partial denture – mandibular	$22
D5510 Repair broken complete denture base	$44
D5520 Replace missing or broken teeth – complete denture (each tooth)	$41
D5610 Repair resin denture base	$46
D5620 Repair cast framework	$49
D5630 Repair or replace broken clasp	$56
D5640 Replace broken teeth – per tooth	$42
D5650 Add tooth to existing partial denture	$52
D5660 Add clasp to existing partial denture	$57
D5710 Rebase complete maxillary denture	$138
D5711 Rebase complete mandibular denture	$133
D5720 Rebase maxillary partial denture	$127
D5721 Rebase mandibular partial denture	$124
D5730 Reline complete maxillary denture (chairside)	$82
D5731 Reline complete mandibular denture (chairside)	$82
D5740 Reline maxillary partial denture (chairside)	$77
D5741 Reline mandibular partial denture (chairside)	$75
D5750 Reline complete maxillary denture (laboratory)	$114
D5751 Reline complete mandibular denture (laboratory)	$114
D5760 Reline maxillary partial denture (laboratory)	$112
D5761 Reline mandibular partial denture (laboratory)	$112

D5850 Tissue conditioning (maxillary)	$36
D5851 Tissue conditioning (mandibular)	$36
D6930 Recement fixed partial denture	$33
D6980 Fixed partial denture repair, by report	$63

Oral Surgery

	Co-Pay Amount
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$39
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$65
D7220 Removal of impacted tooth - soft tissue	$84
D7230 Removal of impacted tooth - partially bony	$110
D7240 Removal of impacted tooth - completely bony	$130
D7250 Surgical removal of residual tooth roots (cutting procedure)	$73
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$154
D7280 Surgical access of an unerupted tooth	$171
D7310 Alveoloplasty in conjunction with extractions - per quadrant	$84
D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	$68
D7320 Alveoloplasty not in conjunction with extractions - per quadrant	$155
D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	$124
D7471 Removal of exostosis	$259
D7510 Incision and drainage of abscess – intraoral soft tissue	$73
D7910 Suture of recent small wounds up to 5 cm	$110
D7971 Excision of pericoronal gingiva	$61

Additional Procedures Covered as Intermediate Services

D6092 Recement implant/abutment supported crown	$24
D6093 Recement implant/abutment supported fixed partial denture	$33

Class C Major

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- There is no waiting period for major services.
- The annual benefit maximum is $10,000.

You Pay:

- ***High Option***
  - **In-Network:** The co-pay amount shown in the Schedule of Benefits.
  - **Out-of-Network: In full for all charges.** There are no out-of-network benefits available except for emergency services when the services of an in-network provider are not available.

Major Restorative Services

	Co-Pay Amount
D2542 Onlay - metallic - two surfaces – *Limited to once per tooth every 5 years*	$315
D2543 Onlay - metallic - three surfaces – *Limited to once per tooth every 5 years*	$342
D2544 Onlay - metallic - four or more surfaces – *Limited to once per tooth every 5 years*	$362
D2740 Crown - porcelain/ceramic substrate – *Limited to once per tooth every 5 years*	$430
D2750 Crown - porcelain fused to high noble metal – *Limited to once per tooth every 5 years*	$432
D2751 Crown - porcelain fused to predominately base metal – *Limited to once per tooth every 5 years*	$396
D2752 Crown - porcelain fused to noble metal – *Limited to once per tooth every 5 years*	$408
D2780 Crown - 3/4 cast high noble metal – *Limited to once per tooth every 5 years*	$447
D2781 Crown - 3/4 cast predominately base metal – *Limited to once per tooth every 5 years*	$419
D2782 Crown – ¾ cast noble metal – Limited to once per tooth every 5 years	$431
D2783 Crown – ¾ porcelain/ceramic – *Limited to once per tooth every 5 years*	$456
D2790 Crown – full cast high noble metal – *Limited to once per tooth every 5 years*	$412
D2791 Crown - full cast predominately base metal – *Limited to once per tooth every 5 years*	$381
D2792 Crown - full cast noble metal – *Limited to once per tooth every 5 years*	$389
D2794 Crown – titanium – *Limited to once per tooth every 5 years*	$417
D2950 Core buildup, including any pins	$90
D2954 Prefabricated post and core, in addition to crown	$109
D2980 Crown repair, by report	$70

Not covered:

- *Gold foil restorations*
- *Restorations for cosmetic purposes only*

Endodontic Services

	Co-Pay Amount
D3310 Anterior root canal (excluding final restoration)	$328
D3320 Bicuspid root canal (excluding final restoration)	$400
D3330 Molar root canal (excluding final restoration)	$508
D3346 Retreatment of previous root canal therapy-anterior	$426
D3347 Retreatment of previous root canal therapy-bicuspid	$502
D3348 Retreatment of previous root canal therapy-molar	$600
D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$175
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$87
D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)	$250
D3410 Apicoectomy/periradicular surgery - anterior	$342
D3421 Apicoectomy/periradicular surgery - bicuspid (first root)	$359
D3425 Apicoectomy/periradicular surgery - molar (first root)	$420
D3426 Apicoectomy/periradicular surgery (each additional root)	$146
D3450 Root amputation - per root	$208
D3920 Hemisection (including any root removal) - not including root canal therapy	$165

Periodontal Services

	Co-Pay Amount
D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces, per quadrant	$226
D4211 Gingivectomy or gingivoplasty – one to three teeth, per quadrant	$81
D4240 Gingival flap procedure, including root planing, four of more contiguous teeth or bounded teeth spaces per quadrant	$298
D4249 Clinical crown lengthening-hard tissue	$332
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant	$510
D4261 Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant	$285
D4270 Pedicle soft tissue graft procedure	$363
D4271 Free soft tissue graft procedure (including donor site surgery)	$376
D4273 Subepithelial connective tissue graft procedures (including donor site surgery)	$421
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis - *Limited to once per lifetime*	$51

Prosthodontic Services

	Co-Pay Amount
D5110 Complete denture - maxillary *Limited to once per tooth every five years*	$510
D5120 Complete denture - mandibular *Limited to once per tooth every five years*	$510
D5130 Immediate denture - maxillary *Limited to once per tooth every five years*	$544
D5140 Immediate denture - mandibular *Limited to once per tooth every five years*	$544
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) *Limited to once per tooth every five years*	$407
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) *Limited to once per tooth every five years*	$435
D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) *Limited to once per tooth every five years*	$559
D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) *Limited to once per tooth every five years*	$559
D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth) *Limited to once per tooth every five years*	$295
D6210 Pontic - cast high noble metal *Limited to once per tooth every five years*	$399
D6211 Pontic - cast predominately base metal *Limited to once per tooth every five years*	$375

Prosthodontic Services	
	Co-Pay Amount
D6212 Pontic - cast noble metal *Limited to once per tooth every five years*	$391
D6214 Pontic – titanium *Limited to once per tooth every five years*	$405
D6240 Pontic - porcelain fused to high noble metal *Limited to once per tooth every five years*	$407
D6241 Pontic - porcelain fused to predominately base metal *Limited to once per tooth every five years*	$373
D6242 Pontic - porcelain fused to noble metal *Limited to once per tooth every five years*	$388
D6245 Pontic - porcelain/ceramic *Limited to once per tooth every five years*	$384
D6545 Retainer - cast metal for resin bonded fixed prosthesis	$178
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$196
D6600 Inlay – porcelain/ceramic, two surfaces – Limited to once per tooth every 5 years	$356
D6601 Inlay – porcelain/ceramic, three or more surfaces – Limited to once per tooth every 5 years	$389
D6602 Inlay – cast high noble metal, two surfaces – Limited to once per tooth every 5 years	$342
D6603 Inlay – cast high noble metal, three or more surfaces – Limited to once per tooth every 5 years	$391
D6604 Inlay – cast predominantly base metal, two surfaces – Limited to once per tooth every 5 years	$341
D6605 Inlay – cast predominantly base metal, three or more surfaces – Limited to once per tooth every 5 years	$379
D6606 Inlay – cast noble metal, two surfaces – Limited to once per tooth every 5 years	$343
D6607 Inlay – cast noble metal, three or more surfaces – Limited to once per tooth every 5 years	$384
D6608 Onlay – porcelain/ceramic, two surfaces – Limited to once per tooth every 5 years	$394
D6609 Onlay – porcelain/ceramic, three or more surfaces – Limited to once per tooth every 5 years	$418
D6610 Onlay – cast noble metal, two surfaces – Limited to once per tooth every 5 years	$412
D6611 Onlay – cast noble metal, three or more surfaces – Limited to once per tooth every 5 years	$381
D6612 Onlay – cast predominantly base metal, two surfaces – Limited to once per tooth every 5 years	$409
D6613 Onlay – cast predominantly base metal, three or more surfaces – Limited to once per tooth every 5 years	$368
D6614 Onlay – cast noble metal, two surfaces – Limited to once per tooth every 5 years	$408
D6615 Onlay – cast noble metal, three or more surfaces – Limited to once per tooth every 5 years	$368
D6740 Crown - porcelain/ceramic *Limited to once per tooth every five years*	$381
D6750 Crown - porcelain fused to high noble metal – *Limited to once per tooth every 5 years*	$435
D6751 Crown - porcelain fused to predominately base metal *Limited to once per tooth every five years*	$401
D6752 Crown - porcelain fused to noble metal *Limited to once per tooth every five years*	$411
D6780 Crown - 3/4 cast high noble metal *Limited to once per tooth every five years*	$388
D6781 Crown - 3/4 cast predominately base metal *Limited to once per tooth every five years*	$394
D6782 Crown - 3/4 cast noble metal – *Limited to once per tooth every 5 years*	$392
D6783 Crown - 3/4 porcelain/ceramic – *Limited to once per tooth every 5 years*	$418
D6790 Crown - full cast high noble metal – *Limited to once per tooth every 5 years*	$415
D6791 Crown - full cast predominately base metal – *Limited to once per tooth every 5 years*	$389
D6792 Crown - full cast noble metal *Limited to once per tooth every five years*	$399
D6794 Crown – titanium – *Limited to once per tooth every 5 years*	$416
D6972 Prefabricated post and core in addition to fixed partial denture retainer	$99
D6973 Core buildup for retainer, including any pins	$100

Additional Procedures Covered as Major Services	
	Co-Pay Amount
D0160 Detailed and extensive oral evaluation – problem focused, by report – *Limited to once per patient per lifetime*	$53

Not covered:

- *Implants and related services*
- *Cast unilateral removable partial dentures*
- *Precision attachments, personalization, precious metal bases, and other specialized techniques*
- *Replacement of dentures that have been lost, stolen or misplaced*
- *Removable or fixed prostheses initiated prior to the effective date of coverage or inserted/cemented after the coverage ending date*

Class D Orthodontic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- There is no waiting period for orthodontic services.
- There is no lifetime maximum for orthodontia.

You Pay:

- ***High Option***
  - **In-Network:** The co-pay amount shown in the Schedule of Benefits.
  - **Out-of-Network:** In full for all charges. There are no out-of-network benefits available except for emergency services when the services of an in-network provider are not available.

Orthodontic Services - limited to children up to age 19

	Co-Pay Amount
D8010 Limited orthodontic treatment of the primary dentition – *Limited to one treatment per lifetime*	$685
D8020 Limited orthodontic treatment of the transitional dentition – *Limited to one treatment per lifetime*	$894
D8030 Limited orthodontic treatment of the adolescent dentition – *Limited to one treatment per lifetime*	$1007
D8050 Interceptive orthodontic treatment of the primary dentition – *Limited to one treatment per lifetime*	$1240
D8060 Interceptive orthodontic treatment of the transitional dentition – *Limited to one treatment per lifetime*	$1431
D8070 Comprehensive orthodontic treatment of the transitional dentition – *Limited to one treatment per lifetime*	$2829
D8080 Comprehensive orthodontic treatment of the adolescent dentition – *Limited to one treatment per lifetime*	$2885
D8210 Removable appliance therapy – *Limited to one treatment per lifetime*	$583
D8220 Fixed appliance therapy– *Limited to one treatment per lifetime*	$662
D8660 Pre-orthodontic treatment visit– *Limited to one treatment per lifetime*	$35
D8670 Periodic orthodontic treatment visit (as part of contract)	$116
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)) – *Limited to one treatment per lifetime*	$286

Not covered:

- *Orthodontic care for persons age 19 and over*
- *Repair of damaged orthodontic appliances*
- *Replacement of lost or missing appliance*

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, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- The annual benefit maximum is $10,000.

You Pay:

- ***High Option***
  - **In-Network:** The co-payment shown in the Benefit Schedule
  - **Out-of-Network:** In full for all charges. There are no out-of-network benefits available except for emergency services when the services of an in-network provider are not available.

Anesthesia Services	
	Co-Pay Amount
D9215 Local anesthesia	$0
D9220 Deep sedation/general anesthesia - first 30 minutes	$141
D9221 Deep sedation/general anesthesia - each additional 15 minutes	$56
Intravenous Sedation	
D9241 Intravenous conscious sedation/analgesia - first 30 minutes	$123
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes	$51
Consultations	
D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$59
Office Visits	
D9440 Office visit - after regularly scheduled hours	$44
Medications	
D9610 Therapeutic drug injection, by report	$23
Post Surgical Services	
D9930 Treatment of complications (post-surgical) unusual circumstances, by report	$0
Miscellaneous Services	
D9940 Occlusal guard, by report	$155
D9941 Fabrication of athletic mouthguard	$95
D9974 Internal bleaching - per tooth	$161

Not covered:

- *Nitrous oxide*
- *Oral sedation*

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, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- The annual benefit maximum is $10,000.

You Pay:

High Option

- **In-Network:** The co-payment shown in the Benefit Schedule.
- **Out-of-Network: In full for all charges.** There are no out-of-network benefits available except for emergency services when the services of an in-network provider are not available.

Anesthesia Services
D9215 Local anesthesia
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)
Office Visits
D9440 Office visit - after regularly scheduled hours
Medications
D9610 Therapeutic drug injection, by report
Post Surgical Services
D9930 Treatment of complications (post-surgical) unusual circumstances, by report
Miscellaneous Services
D9940 Occlusal guard, by report
D9941 Fabrication of athletic mouthguard
D9974 Internal bleaching - per tooth

Not covered:

- *Nitrous oxide*
- *Oral sedation*

Section 6 International Services and Supplies

International Claims Payment	This plan provides a benefit for emergency services when overseas. Emergency services are defined as treatment due to injury, accident or severe pain requiring the services of a dentist which occurs under circumstances where it is neither medically or physically possible for you to be treated by an in-network plan provider. We will reimburse you for emergency services up to $100 per member per year.
Finding an International Provider	This plan provides a benefit for international emergency services when services are received from a licensed dentist.
Filing International Claims	The following should be provided when submitting a claim for International emergency services: • Name of country where services were received • American Dental Association procedure codes • Translation of language to English • Translation into US currency or accurate day rate • Tooth number(s) and/or quadrants • Date(s) of service • Dentist name
Customer Service Website and Phone Numbers	Our plan website is www. MyCBFed.com. You may also contact us by phone at 1-877-692-2468.

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:

- Any dental service or treatment not specifically listed as a covered service;
- 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 for which the cost is later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law;
- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;
- Any dental treatment started prior to your effective date for eligibility of benefits;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services which in the opinion of the in-network dentist or specialist are not necessary treatment to establish and/or maintain your oral health;
- Any service that is not consistent with the normal and/or usual services provided by the in-network dentist or specialist or which in the opinion of the in-network dentist or specialist would endanger your health;
- 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 strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD);
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- The cost of hospitalization, pharmaceuticals, drugs or medications;
- Any service or procedure which the in-network dentist or specialist is unable to perform because of your general health or physical limitations;
- Treatment for cysts, neoplasms and malignancies;
- General anesthesia;
- 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;
- Adjunctive dental care services are covered by other medical insurance even when provided by a general dentist or oral surgeon;

- Services and treatment of any dentist other than an in-network general dentist or specialist, except out-of-area emergency services up to co-pay amount of $100 per member per year. Emergency services are defined as treatment due to injury, accident or severe pain requiring the services of a dentist which occurs under circumstances where it is neither medically or physically possible for you to be treated by an in-network provider.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

For in-network services, there are no claims for you to file.

This plan does not offer an out-of-network benefit. If you see an out-of-network provider for emergency services, the provider should submit a standard ADA claim form to:

Humana/CompBenefits Dental Advantage

PO Box 7533

Chicago, IL 60680-7533

If you see an international dentist for emergency services, the provider or member should submit a claim form with the following information: name of the country in which the work was performed, the dentist's name, the American Dental Association code(s), the tooth number(s) and the date(s) of service. Claims must be submitted in U.S. dollars and mailed to the address shown above.

Deadline for Filing Your Claim

For emergency and international claims, you have one year from the date of service to file your claim.

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 for OPM to review disputed claims.**

Disputed Claim Steps

1 Ask us in writing to reconsider our initial decision. You mustsubmit a formal written statement to our Grievance and Appeals Department at: PO Box 14729 Lexington, KY 40512-4729 within one (1) year from occurrence of the events upon which the grievance is based, and must contain a statement of the action requested, your name, address, telephone number, Member number, signature and the date.

2 We have 60 days from the date we received your request torender a decision to either pay or deny the claim and communicate such decision back to you. However, if the grievance involves collection of information from outside our service area, an additional thirty (30) days will be allowed for processing.

3 If the dispute is not resolved through the reconsideration process, you may request a review of the denial. You must request reconsideration by the Grievance Panel within sixty (60) days after receipt of the initial grievance written decision by submitting a written request to the our Grievance and Appeals Department at: PO Box 14729 Lexington, KY 40512-4729.

4 If you do not agree with our final decision, you may request an independent third party, mutually agreed upon by us and OPM, review the decision. The decision of the independent third party is binding and is the final review of your claim. To request a third-party review, you must submit a written request to our Grievance and Appeals Department at: PO Box 14729 Lexington, KY 40512-4729.

Section 9 Definitions of Terms We Use in This Brochure

Annual Benefit Maximum	The maximum annual benefit that you can receive per person.
Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
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.
Co-pay	Co-pay or co-payment is a fixed amount of money you pay directly to the dentist when you receive covered services.
Emergency Services	Treatment due to injury, accident or severe pain requiring the services of a dentist which occurs under circumstances where it is neither medically or physically possible for you to be treated by plan provider.
Enrollee	The Federal employee or annuitant enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Generally Accepted Dental Protocols	The standards set by the American Dental Association or which are customarily used for dental care. Humana/CompBenefits reserves the right to determine the level of necessary treatment.
Missing Tooth Clause	The exclusion of any service or supply rendered to replace a tooth lost prior to the effective date of coverage. When the procedure/appliance is to replace only the tooth lost prior to the member's effective date, the procedure/appliance is not covered. When the missing tooth is repaired in conjunction with other extractions after the effective date, the procedure/appliance is covered.
Plan Allowance	The amount we use to determine our payment for out-of-network services.
Preexisting Condition	Any disease or condition of the teeth or supporting structures which existed on the effective date of coverage.
We/Us	Humana/CompBenefits Dental Advantage.
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.
- 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 877-692-2468 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.

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.

Summary of Benefits

- **Do not rely on this chart alone.** This page summarizes specific 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.

Benefit	You Pay:
High Option Benefits	
Class A (Basic) Services – preventive and diagnostic	Nothing
Class B (Intermediate) Services – includes minor restorative services	Co-Pay
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	Co-pay
Class D Services – orthodontic No Lifetime Maximum	Co-pay

Rate Information

How to find your monthly and bi-weekly rates:

- 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 and plan option.

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

State	3 Digit Zip Code	Rating Area	State	3 Digit Zip Code	Rating Area
AL	Entire State	**1**	**MD**	206-218	**2**
AR	Entire State	**5**	**MO**	Entire State	**1**
AZ	Entire State	**2**	**MS**	Entire State	**5**
CA	Entire State	**4**	**NC**	Entire State	**5**
CO	Entire State	**4**	**OH**	430-432	**3**
DC	Entire State	**2**	**OH**	Remaining Zip Codes	**1**
FL	Entire State	**2**	**OK**	Entire State	**3**
GA	300-303, 311	**3**	**SC**	Entire State	**5**
GA	Remaining Zip Codes	5	TN	Entire State	1
IL	Entire State	1	TX	Entire State	3
IN	Entire State	1	UT	Entire State	1
KS	Entire State	1	VA	201, 220-226	2
KY	Entire State	1	VA	230-232, 238	5
LA	Entire State	5	VA	Remining Zip Code	4
			WV	Entire State	3

Monthly and Bi-Weekly Rates

Rating Area	Monthly Self Only	Monthly Self Plus One	Monthly Self and Family	Bi-Weekly Self Only	Bi-Weekly Self Plus One	Bi-Weekly Self and Family
1	$21.45	$42.88	$64.33	$9.90	$19.79	$29.69
2	$21.99	$43.98	$65.98	$10.15	$20.30	$30.45
3	$23.21	$46.43	$69.64	$10.71	$21.43	$32.14
4	$30.14	$60.26	$90.39	$13.91	$27.81	$41.72
5	$31.74	$63.48	$95.23	$14.65	$29.30	$43.95