EMBLEMHEALTH Dental

(Formerly GHI Dental)

http://www.emblemhealth.com

EmblemHealth®

2015

Dental PPO Plan

High Option Plan Serving: All of New York and New Jersey counties of Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex and Union. Connecticut counties of Fairfield, Litchfield, New Haven. Pennsylvania counties Pike and Monroe.

Enrollment Options for this Plan:

- **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

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

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The Act directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants, and their eligible family members. The result is 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 EmblemHealth (formerly GHI) under our contract OPM01-FEDVIP-01AP-5 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

EmblemHealth
55 Water Street
New York, NY 10041
1-800-624-2414

www.EmblemHealth.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, 2015, unless those benefits are also shown in this brochure.

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

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

EmblemHealth is responsible for the selection of in-network providers in your area. Contact us at 1-800-624-2414 for the names of participating providers or to request a provider directory. You may also view the most current directory via our web site at www.EMBLEMHEALTH.com. The 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 may nominate him or her to join. Nomination forms are available on our web site, or call us and we will have a form sent to you. You cannot change plans, outside of Open Season, because of changes to the provider network.

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

The EmblemHealth 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, www.EMBLEMHEALTH.com then click on the "Privacy and Security" 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 calling1-800-624-2414.

Table of Contents

FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas, regional dental Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) plans, and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Visit www.opm.gov/healthcare-insurance/dental-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 2014 Open Season, your coverage will begin on January 1, 2015. Premium deductions will start with the first full pay period beginning on/after January 1, 2015. 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 10, 2014 through December 8, 2014. You do not need to re-enroll each Open Season unless you wish to change plans or plan options; your coverage will continue from the previous year. In addition to the annual Open Season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2, Enrollment, for more information.
Continued Group Coverage After Retirement	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may also be able to continue enrollment after your death. Please see Section 1, Eligibility, for more information.
Waiting Period	The only waiting period is for orthodontic services. To meet this requirement, the person receiving the services must be enrolled in this plan for the entire waiting period.

How We Have Changed in 2015

- Increased the Annual Benefit Maximum from $5,000 in 2014 to unlimited for 2015.
- Increased the Implant Allowance from $600 to $1,000.
- Increased the Orthodontia Lifetime Maximum from $2,000 to $3,000.

Rates

The 2015 Self Only, Self Plus One and Self and Family rates are provided on page 32 of this Brochure.

Section 1 Eligibility

Federal Employees

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

Federal Annuitants

You are eligible to enroll if you:

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

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

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

Survivor Annuitants

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

Compensationers

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

Family Members

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

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

*If you would marry but you live in a state that does not allow same-sex couples to marry.

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 2015.

Note: You cannot enroll or change enrollment in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, PostalEase, EBIS, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

Enrollment Types

Self Only: A Self Only enrollment covers only you as the enrolled employee or annuitant. You may choose a Self Only enrollment even though you have a family; however, your family members will not be covered under FEDVIP.

Self Plus One: A Self Plus One enrollment covers you as the enrolled employee or annuitant plus one eligible family member whom you specify. You may choose a Self Plus One enrollment even though you have additional eligible family members, but the additional family members will not be covered under FEDVIP.

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

Self and Family: A Self and Family enrollment covers you as the enrolled employee or annuitant and all of your eligible family members. You must list all eligible family members when enrolling.

Dual Enrollment

If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee or annuitant, you may enroll in a dental and/or vision plan during the November 10, through December 8, 2014, Open Season. Coverage is effective January 1, 2015.

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
Marriage	Yes	Yes	No	No	Yes
Acquiring an eligible family member (non-spouse)	No	Yes	No	No	No
Losing a covered family member	No	No	Yes	No	No
Losing other dental/vision coverage (eligible or covered person)	Yes	Yes	No	No	No
Moving out of regional plan's service area	No	No	No	No	Yes
Going on active military duty, non-paystatus (enrollee or spouse)	No	No	No	Yes	No
Returning to pay status from active military duty (enrollee or spouse)	Yes	No	No	No	No
Returning to pay status from Leave without pay	**Yes (if enrollment cancelled during LWOP)**	No	No	No	**Yes (if enrollment cancelled during LWOP)**
Annuity/ compensation restored	Yes	Yes	Yes	No	No
Transferring to an eligible position*	No	No	No	Yes	No

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

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

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

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

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

Canceling an enrollment

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

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

When Coverage Stops

Coverage ends when you:

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

Coverage for a family member ends when:

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

Continuation of Coverage

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

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

FSAFEDS/High Deductible Health Plans and FEDVIP

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

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 2015. 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.

You will be required to submit your claims on behalf of the EmblemHealth Dental 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 when you enroll. You should carry your ID card with you at all times. You must show it 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, call us at 1-800-624-2414. You may also request replacement cards through the EmblemHealth website, www.EMBLEMHEALTH.com. 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.
Where You Get Covered Care	You get care from "plan providers". You will only pay deductibles and will not have to file claims.
Plan Providers	We list plan providers in the provider directory, which we update periodically. The list is on our website at: www.EMBLEMHEALTH.com or you may call us at 1-800-624-2414.
In-Network	No referrals are necessary. No primary care dentist need be selected. Your dentist will submit claim forms to EmblemHealth for payment.
Out-of-Network	Members must submit claim forms to EmblemHealth and EmblemHealth will reimburse members for covered services.
Pre-Certification	Pre-certifications (also called pre-treatment estimates) are not mandatory, but EmblemHealth suggests pre-certification of benefits for procedures including surgeries, prosthetics, major restorations, orthodontics and other expensive treatments. Pre-certifications are also recommended for treatment costing $300 or more.
First Payor	When you visit a provider who participates with both, your FEHB plan and your FEDVIP plan, the FEHB plan will pay benefit s first. The FEDVIP plan allowance will be the prevailing charge in these cases. You are responsible for the difference between the FEHB and FEDVIP benefit payments and the FEDVIP plan allowance. We are responsible for facilitating the process with the FEHB first payor. 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.
Coordination of Benefits	We will 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.
Service Area	To enroll in this plan, you must live in our service area. This is where our providers practice. Our service area is: All of New York and the New Jersey counties of Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex and Union. Connecticut counties of Fairfield, Litchfield, New Haven. Pennsylvania counties Pike and Monroe.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. 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. If your family members live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a nationwide plan. If you move outside of our service area, 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.

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 expense you must incur for certain out-of-network covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. Example: In our plan, the out-of-network calendar year deductible for an individual is $50 and family $150.
Annual Benefit Maximum	Once you reach this amount, you are responsible for all charges. This plan's annual maximum is unlimited per covered person.
In-Network Services	EmblemHealth pays 100% of the Preferred schedule of allowances to the EmblemHealth network provider for covered services.
Out-of-Network Services	Member must pay the difference of the EmblemHealth fee schedule and the dentist's normal charges.
Emergency Services	EmblemHealth will pay 100% of the plan allowance for emergency services, the same as any other covered benefit. For emergencies incurred outside of our service area, EmblemHealth will pay 100% of the plan allowance for emergency benefits only. No other services are covered unless prior authorization is received from EmblemHealth.

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 and meet generally accepted dental protocols.
- There is no deductible for Basic services.
- The annual benefit maximum for Basic, Intermediate, Major and General services is unlimited per covered person.

You Pay:

High Option

- **In-Network:** EmblemHealth pays 100% of the Preferred Schedule of Allowances to the EmblemHealth Network Provider for the covered Basic services listed below.
- **Out-of-Network:** EmblemHealth reimburses you 100% of the Preferred Schedule of Allowances for the covered Basic Services. You are responsible for paying the provider the difference between EmblemHealth's reimbursement and the non-network provider's charge for covered services.

Diagnostic and Treatment Services

D0120 Periodic oral evaluation – *Limited to two in each calendar year.*

D0140 Limited oral evaluation – problem focused – *Limited to one every 12 consecutive months*

D0150 Comprehensive oral evaluation – patient – *Limited to one every 36 consecutive months for each dental provider.*

D0180 Comprehensive periodontal evaluation – patient – *Limited to one every 36 consecutive months for each dental provider.*

D0210 Intraoral – complete series (including bitewings) – *Limited to one every 36 consecutive months.*

D0220 Intraoral – periapical first film

D0230 Intraoral – periapical – each additional film

D0240 Intraoral – occlusal film

D0270 Bitewing – single film – *Limited to four bitewing x-rays in each calendar year.*

D0272 Bitewings – two films – *Limited to four bitewing x-rays in each calendar year.*

D0273 Bitewings – three films – *Limited to four bitewing x-rays in each calendar year.*

D0274 Bitewings – four films – *Limited to four bitewing x-rays in each calendar year.*

D0277 Vertical bitewings – 7 to 8 films

D0425 Caries susceptibility tests

D0330 Panoramic film – *Limited to one every 36 consecutive months.*

Preventive Services

D1110 Prophylaxis – adult – *Limited to two in each calendar year*

D1120 Prophylaxis – child – *Limited to two in each calendar year, to age 12.*

D1206 Topical fluoride varnish – *Limited to two treatments of topical of topical application of fluoride or topical fluoride varnish in 12 consecutive months, to age 19.*

D1208 Topical application of fluoride (excluding prophylaxis) – *Limited to two treatments of topical of topical application of fluoride or topical fluoride varnish in 12 consecutive months, to age 19.*

D1351 Sealant – per tooth – *Limited to permanent molars through age 18. One sealant per tooth in a 3-year period*

D1510 Space maintainer – fixed – unilateral – *Limited to one space maintainer per covered dependent child per lifetime. Eligible until the end of the calendar year in which the child reaches 19.*

D1515 Space maintainer – fixed – bilateral – *Limited to one space maintainer per covered dependent child per lifetime. Eligible until the end of the calendar year in which the child reaches 19.*

Preventive Services - continued on next page

Preventive Services (cont.)
D1520 Space maintainer – removable – unilateral – *Limited to one space maintainer per covered dependent child per lifetime. Eligible until the end of the calendar year in which the child reaches 19.*
D1525 Space maintainer – removable – bilateral – *Limited to one space maintainer per covered dependent child per lifetime. Eligible until the end of the calendar year in which the child reaches 19.*
D1550 Re-cementation of space maintainer. *Eligible until the end of the calendar year in which the child reaches 19.*
Additional Procedures covered as Basic Services
D9110 Palliative treatment of dental pain – minor procedure – *Limited to one palliative service for each member in each calendar year.*
Not covered: • *Plaque control programs* • *Oral hygiene instruction* • *Dietary instructions* • *Sealants for teeth other than permanent molars* • *Over-the-counter dental products, such as teeth whiteners, toothpaste, dental floss*

Class B Intermediate

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary and meet generally accepted dental protocols.
- The calendar year deductible is: $50 per person ($150 per family) for Intermediate, Major and General services (Class B & Class C) for out-of-network coverage only.
- The annual benefit maximum for Basic, Intermediate, Major and General services is unlimited per covered person.

You Pay:

High Option

- **In-Network:** EmblemHealth pays 100% of the Preferred Schedule of Allowances to the EmblemHealth Network Provider for covered Intermediate services listed below.
- **Out-of-Network:** After you meet the annual deductible, EmblemHealth reimburses you 100% of the Preferred Schedule of Allowances for the covered Intermediate services listed below. You are responsible for paying the provider the difference between EmblemHealth's reimbursement and the non-network provider's charge for covered services.

Minor Restorative Services

D2140 Amalgam – one surface, primary or permanent
D2150 Amalgam – two surfaces, primary or permanent
D2160 Amalgam – three surfaces, primary or permanent
D2161 Amalgam – four or more surfaces, primary or permanent
D2330 Resin-based composite – one surface, anterior
D2331 Resin-based composite – two surfaces, anterior
D2332 Resin-based composite – three surfaces, anterior
D2335 Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2391 Resin – one surface, posterior – *Pre-molars only*
D2392 Resin – two surfaces, posterior – *Pre-molars only*
D2393 Resin – three surfaces, posterior – *Pre-molars only*
D2394 Resin – four surfaces, posterior – *Pre-molars only*
D2910 Re-cement inlay – *Limited to once per 6 month period*
D2920 Re-cement crown – *Limited to once per 6 month period*
D2930 Prefabricated stainless steel crown – primary tooth – *Limited to one per patient, per tooth, per lifetime*
D2931 Prefabricated stainless steel crown – permanent tooth – *Limited to one per patient, per tooth, per lifetime*
D2951 Pin retention – per tooth, in addition to restoration

Minor Restorative Services - continued on next page

Minor Restorative Services (cont.)

Not Covered:

- *Restorations, including veneers, which are placed for cosmetic purposes only*
- *Gold foil restorations*
- *Temporary fillings*
- *The Schedule of Allowances imposes a maximum benefit for fillings done on the same tooth by the same Dentist or Provider within a six (6) month period. GHI will not pay more than this maximum benefit for fillings for each Member in any six (6) month period.*
- *If two (2) fillings are done on the same posterior tooth on the same day, GHI's allowance will be up to the Scheduled or Allowed amount for a three (3) surface amalgam.*

Endodontic Services

D3220 Therapeutic pulpotomy (excluding final restoration)

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 once every 36 consecutive months.

D4342 Periodontal scaling and root planning – one to three teeth, per quadrant - limited to once every 36 consecutive months.

D4910 Periodontal maintenance - limited to two in each calendar year.

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

D5720 Rebase maxillary partial denture

D5721 Rebase mandibular partial denture

D5730 Reline complete maxillary denture (chairside)

D5731 Reline complete mandibular denture (chairside)

D5740 Reline maxillary partial denture (chairside)

D5741 Reline mandibular partial denture (chairside)

D5750 Reline complete maxillary denture (laboratory)

D5751 Reline complete mandibular denture (laboratory)

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D5760 Reline maxillary partial denture (laboratory)
D5761 Reline mandibular partial denture (laboratory) Rebase/Reline – *Limited to once in a 36-month period*
D5850 Tissue conditioning (maxillary)
D5851 Tissue conditioning (mandibular)
D6930 Recement fixed partial denture
D6980 Fixed partial denture repair, by report
Not Covered:
• Denture rebase or repair within six months of the inserion date of a new denture.
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
D7250 Surgical removal of residual tooth roots (cutting procedure)
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 toothe 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

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 and meet generally accepted dental protocols.
- The calendar year deductible is: $50 per person ($150 per family) for Intermediate, Major and General services (Class B & Class C) for out-of-network coverage only.
- The annual benefit maximum for Basic, Intermediate, Major and General services is unlimited per covered person.

You Pay:

High Option

- **In-Network:** EmblemHealth pays 100% of the Preferred Schedule of Allowances to the EmblemHealth Network Provider for covered Major services listed below.
- **Out-of-Network:** After you meet the annual deductible, EmblemHealth reimburses you 100% of the Preferred Schedule of Allowances for the covered Major services listed below. You are responsible for paying the provider the difference between EmblemHealth's reimbursement and the non-network provider's charge for covered services.

Major Restorative Services

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

D2542 Onlay - metallic - two surfaces

D2543 Onlay - metallic - three surfaces

D2544 Onlay - metallic - four or more surfaces

D2740 Crown - porcelain/ceramic substrate

D2750 Crown - porcelain fused to high noble metal

D2751 Crown - porcelain fused to predominately base metal

D2752 Crown - porcelain fused to noble metal

D2780 Crown - 3/4 cast high noble metal

D2781 Crown - 3/4 cast predominately base metal

D2783 Crown - 3/4 porcelain/ceramic

D2790 Crown - full cast high noble metal

D2791 Crown - full cast predominately base metal

D2792 Crown - full cast noble metal

D2794 Crown - titanium

D2950 Core buildup, including any pins

D2954 Prefabricated post and core, in addition to crown

D2980 Crown repair, by report

Not covered:

- *Gold foil restorations*
- *Sedative restorations*
- *Restorations for cosmetic purposes only*
- *Composite resin inlays*
- *Temporary crowns*

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.)
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 contiguous teeth or bounded teeth spaces, per quadrant
D4211 Gingivectomy or gingivoplasty - one to three teeth, per quadrant
D4240 Gingival flap procedure, including root planing, four of more contiguous teeth or tooth bounded spaces per quadrant
D4241 Gingival flap procedure, including root planning, one to three contiguous teeth or tooth bounded spaces per quadrant
D4249 Clinical crown lengthening-hard tissue
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or thooth bounded spaces per quadrant - limited to once every 36 consecutive months.
D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant - limited to once every 36 consecutive 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 once per lifetime*
Prosthodontic Services
D5110 Complete denture - maxillary
D5120 Complete denture - mandibular
D5130 Immediate denture - maxillary
D5140 Immediate denture - mandibular
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)
D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth)
D6210 Pontic - cast high noble metal

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6211 Pontic - cast predominately base metal
D6212 Pontic - cast noble metal
D6214 Pontic – titanium
D6240 Pontic - porcelain fused to high noble metal
D6241 Pontic - porcelain fused to predominately base metal
D6242 Pontic - porcelain fused to noble metal
D6245 Pontic - porcelain/ceramic
D6519 Inlay/onlay – porcelain/ceramic
D6520 Inlay – metallic – two surfaces
D6530 Inlay – metallic – three or more surfaces
D6543 Onlay – metallic – three surfaces
D6544 Onlay – metallic – four or more surfaces
D6545 Retainer - cast metal for resin bonded fixed prosthesis
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6740 Crown - porcelain/ceramic
D6750 Crown - porcelain fused to high noble metal
D6751 Crown - porcelain fused to predominately base metal
D6752 Crown - porcelain fused to noble metal
D6780 Crown - 3/4 cast high noble metal
D6781 Crown - 3/4 cast predominately base metal
D6782 Crown - 3/4 cast noble metal
D6783 Crown - 3/4 porcelain/ceramic
D6790 Crown - full cast high noble metal
D6791 Crown - full cast predominately base metal
D6792 Crown - full cast noble metal
D6973 Core buildup for retainer, including any pins
Not covered:
• *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 and meet generally accepted dental protocols.
- There is no calendar year deductible for Orthodontic services.
- The waiting period for orthodontic services is 12 months. The person receiving services must be covered under this plan for the entire waiting period.
- The lifetime maximum for orthodontic services is $3,000.
- The annual benefit maximum does not apply to Orthodontic services.

You Pay:

High Option

- **In-Network:** The participating network dentist will accept EmblemHealth's payment as payment in full for the first 20 months of covered comprehensive orthodontic treatment. EmblemHealth will issue payment directly to the participating network practice. There is no limit on the total number of months required for the completion of a full course of orthodontic treatment. For any remaining treatment time, the subscriber is responsible for paying the provider's charge.
- **Out-of-Network:** EmblemHealth will issue payment to the subscriber for the first 20 months of active comprehensive orthodontic treatment. The subscriber is responsible for claim submission to EmblemHealth, and EmblemHealth will issue payment directly to the subscriber. There is no limit on the total number of months required for the completion of a full course of orthodontic treatment. The subscriber is responsible for paying the provider the difference between EmblemHealth's reimbursement and the non-network provider's charge for services.

Orthodontic Services

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))

Orthodontic Services - continued on next page

Orthodontic Services (cont.)

Not covered:

- *Repair of damaged orthodontic appliances*
- *Replacement of lost or missing appliance*
- *Missed appointments*
- *Habit control appliances*
- *Addition charges for cosmetic banding options*
- *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 and meet generally accepted dental protocols.
- The calendar year deductible is: $50 per person ($150 per family) for Intermediate, Major and General services for out-of-network coverage only.
- The annual benefit maximum for Basic, Intermediate, Major and General services is unlimited per covered person.

You Pay:

High Option

- **In-Network:** EmblemHealthpays 100% of the Preferred Schedule of Allowances to the EmblemHealth Network Provider for covered General services listed below.
- **Out-of-Network:** After you meet the annual deductible, EmblemHealth reimburses you 100% of the Preferred Schedule of Allowances for the covered General services listed below. You are responsible for paying the provider the difference between EmblemHealth's reimbursement and the Non-Network Provider's charge for covered services.

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)

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 - *Limited to one per 12 month period for patients age 13 or over*

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

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

Not covered:

- *Nitrous oxide*
- *Oral sedation*

Section 6 International Services and Supplies

International Claims Payment	Claims will be reimbursed as out-of-network at the appropriate currency exchange rate.
Finding an International Provider	The EmblemHealth Preferred Dental network does not include participating dentists outside the U.S.
Filing International Claims	Bills and receipts should be itemized and show: • Covered member's name and ID number • Name and address of the physician or facility that provided the service or supply • Dates you received the services or supplies • Diagnosis • Type of each service or supply • The charge for each services or supply • A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN), and • Receipts, if you paid for your services. **Submit your claimsto:** EmblemHealth Inc. P.O. Box 3000 New York, New York 10116-3000
Customer Service Website and Phone Numbers	For claims questions and assistance, call us at 1-800-624-2414, or visit us at www.EMBLEMHEALTH.com.

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 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 law or regulation of any governmental 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, or similar person or group;
- Services and treatment performed prior to your effective coverage date including orthodontic treatment;
- Services and treatment rendered to replace a tooth lost prior to the effective date of coverage;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatment which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist (Services determined to be unnecessary or which do not meet accepted standards of dental practice are not billable to you by a participating dentist unless the dentist notifies you of your liability prior to treatment and you choose to receive the treatment. Participating dentists should document such notification in their records.);
- Services and treatment not meeting accepted standards of dental practice;
- Services 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;
- 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 that are covered by other medical insurance even when provided by a general dentist or oral surgeon.
- Care furnished without charge to the patient;
- Habit breaking devices, or adjustment thereof;
- Services subject to no-fault automobile insurance;

- Treatment plans or rendered services that include surgeries, prosthetics, major restorations, orthodontics and other high-dollar treatments are subject to professional claim review to assess benefit amounts and determine if alternate benefits apply;
- When a more costly material or service is substituted for a less costly material or service having the same function, the allowance for the less costly material or service will be applied.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

You must file a claim for services you received outside the plan's service area. Submit the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payer -- such as the Medicare Summary Notice (MSN), and
- Receipts, if you paid for your services.

Submit your claims to:

EmblemHealth
P.O. Box 2838
New York, New York 10116-2838

Deadline for Filing Your Claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Disputed Claims Process

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

Disputed Claim Steps:

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

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

(b) Send your request to us at: EmblemHealth Customer Service Department, 441 Ninth Avenue, New York, NY 10001; and

(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

(d) Include copies of documents that support your claim, such as physicians'

letters, operative reports, bills, dental records, and explanation of benefits

(EOB) forms.

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

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

you the care); or

(b) Write to you and maintain our denial -- go to step 4; or

(c) Ask you or your provider for more information. If we ask your provider, we

will send you a copy of our request—go to step 3.

3 If the dispute is not resolved through the reconsideration process, you may request a review of the denial. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

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

We will write to you with our decision.

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. 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.
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.
Enrollee	The Federal employee or annuitant enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Generally Accepted Dental Protocols	Dental care that is necessary and: • In accordance with the generally accepted standards of good dental practice in the community • Not in excess of the care indicated by generally accepted standards of good dental practice in the community • Not experimental or investigational • Consistent with the symptoms or diagnosis and treatment of the dental condition, disease, injury or ailment • Provided for the diagnosis, or direct care or treatment of the condition, illness, disease or injury that the patient is suffering from.
Missing Tooth Clause	The exclusion of any service or supply rendered to replace a tooth lost prior to the effective date of coverage.
Plan Allowance	The amount we use to determine our payment for out-of-network services.
Preexisting	Any disease or condition of the teeth or supporting structures which were present on the effective date of coverage.
Waiting Period	The amount of time that you must be enrolled in this plan before you can receive orthodontic services.
We/Us	EmblemHealth
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 1-800-624-2414 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

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.

  Below, an asterisk (*) means the item is subject to the $50/$150 calendar year deductible for out-of-network coverage only.

Benefits	You Pay
High Option Benefits (In-Network)	
Class A (Basic) Services – preventive and diagnostic	Nothing
Class B (Intermediate) Services – includes minor restorative services	In-Network: Nothing Out-of-Network: After you meet the annual deductible, EmblemHealth pays 100% of the Preferred Schedule of Allowances *
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	In-Network: Nothing Out-of-Network: After you meet the annual deductible, EmblemHealth pays 100% of the Preferred Schedule of Allowances *
Class A, B, and C Services are subject to an unlimited annual maximum benefit	
Class D Services – orthodontic $3,000 Lifetime Maximum	The participating network dentist will accept EmblemHealth's payment as payment in full for the first 20 months of covered treatment. For any remaining treatment time, you are responsible for paying the provider's charge.

2015 Rate Information

Monthly Rates

High option Self Only	High option Self Plus One	High option Self and Family
$37.44	**$74.84**	**$112.28**

Bi-Weekly Rates

High option Self Only	High option Self Plus One	High option Self and Family
$17.28	**$34.54**	**$51.82**