EMBLEMHEALTH Dental

www.EmblemHealth.com/fedvip-dental

1-877-842-3625

EmblemHealth®

2027

A Regional Dental PPO 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.

IMPORTANT
- Rates: Back Cover
- Changes for 2027: Page 3
- Summary of Benefits: Page 37

This plan has a High and a Standard enrollment option; please see the end of this brochure to determine your rates.

Options:

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

Standard Option - Self Only
Standard Option - Self Plus One
Standard Option - Self and Family

FEDVIP
Federal Employees
Dental And Vision Insurance Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The law directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants, and their eligible family members. In response to the legislation, OPM established the Federal Employees Dental and Vision Insurance Program (FEDVIP). OPM has contracted with dental and vision insurers to offer an array of choices to Federal employees and annuitants. Section 715 of the National Defense Authorization Act for Fiscal Year 2017 (FY 2017 NDAA), Public Law 114-328, expanded FEDVIP eligibility to certain TRICARE-eligible individuals.

This brochure describes the benefits of EmblemHealth (formerly GHI) under our contract OPM02-FEDVIP-02AP-07 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

EmblemHealth
55 Water Street
New York, NY 10041
1-877-842-3625

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, 2027, 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 1-877-842-3625 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 them 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 / Postal Service Health Benefits (PSHB) Program.

We want you to know that protecting the confidentiality of your individually identifiable health information is of the utmost importance to us. To review full details about our privacy practices, our legal duties, and your rights, please visit our website, www. 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 calling 1-877-842-3625.

Discrimination is against the Law

EmblemHealth complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, EmblemHealth does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

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How We Have Changed For 2027

There are no changes for 2027.

FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas, regional dental Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) plans, and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Some TRICARE beneficiaries may not be eligible to enroll in both. Visit www.opm.gov/dental or www.opm.gov/vision for more information.
Enroll Through BENEFEDS	You enroll online at www.BENEFEDS.gov. Please see Section 2, Enrollment, for more information.
Dual Enrollment	If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; (i.e. you or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2026 Open Season, your coverage will begin on January 1, 2027. Premium deductions will start with the first full pay period beginning on/after January 1, 2027. You may use your benefits as soon as your enrollment is confirmed.
Pre-Tax Salary Deduction For Employees	Employees automatically pay premiums through payroll deductions using pre-tax dollars. Annuitants automatically pay premiums through annuity deductions using post-tax dollars. TRICARE enrollees automatically pay premiums through payroll deduction or automatic bank withdrawal (ABW) using post-tax dollars.
Annual Enrollment Opportunity	Each year, an open season will be held, during which you may enroll or change your dental and/or vision plan enrollment. This year, open season runs from November 9, 2026 through midnight EST December 14, 2026. 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 are no waiting periods associated with our plan options.
Compliance with the American Dental Association (ADA)	FEDVIP abides by the Current Dental Terminology (CDT) codification system in accordance with standards set by the American Dental Association (ADA). *Current Dental Terminology (CDT)* Copyright © American Dental Association. All rights reserved.

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, the Postal Service Health Benefits (PSHB) Program, or the Health Insurance Marketplace (Exchange) and your position is not excluded by law or regulation, you are eligible to enroll in FEDVIP. Enrollment in the FEHB Program, PSHB Program or a Health Insurance Marketplace (Exchange) plan is not required.

Temporary/Seasonal Employees

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

Federal Annuitants

You are eligible to enroll if you:

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

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

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

Survivor Annuitants

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

Compensationers

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

TRICARE-eligible individual

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

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

Family Members

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

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

Not Eligible

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

- Deferred annuitants
- Former spouses of employees or annuitants. **Note:** Former spouses of TRICARE-eligible individuals may enroll in a FEDVIP vision plan.
- FEHB/PSHB Temporary Continuation of Coverage (TCC) enrollees
- Anyone receiving an insurable interest annuity who is not also an eligible family member
- Active duty uniformed service members. **Note:** If you are an active duty uniformed service member, your dental and vision coverage will be provided by TRICARE. Your family members will still be eligible to enroll in the TRICARE Dental Plan (TDP).
- Temporary/seasonal employees who do not meet the 130 hours per calendar month for 90 days.

Section 2 Enrollment

Enroll Through BENEFEDS

You must use BENEFEDS to enroll or change enrollment in a FEDVIP plan. BENEFEDS is a secure enrollment website (www.BENEFEDS.gov) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY:711 International 1-571-730-5942 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not want to change plans, **your enrollment will continue automatically. Please Note:** your plan's' premiums may change for 2027.

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

Enrollment Types

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

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

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

Dual Enrollment

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

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee, annuitant, or TRICARE-eligible individual (TEI), you may enroll in a dental and/or vision plan during the November 9, 2026 through midnight EST December 14, 2026, Open Season. Coverage is effective January 1, 2027.

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

New hire/Newly eligible

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

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

Qualifying Life Event

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

The following chart lists the QLEs and the enrollment actions you may take:

Qualifying Life Event: Marriage
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes

Qualifying Life Event: Acquiring an eligible family member (non-spouse)
From Not Enrolled to Enrolled: No
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Losing a covered family member
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: Yes
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Losing other dental/vision coverage (eligible or covered person)
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Moving out of regional plan's service area
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes

Qualifying Life Event: Going on active military duty, non- pay status (enrollee or spouse)
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: Yes
Change from One Plan to Another: No

Qualifying Life Event: Returning to pay status from active military duty (enrollee or spouse)
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Returning to pay status from Leave without pay
From Not Enrolled to Enrolled: **Yes (if enrollment cancelled during LWOP)**
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: **Yes (if enrollment cancelled during LWOP)**

Qualifying Life Event: Annuity/ compensation restored
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Transferring to an eligible position*
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: Yes
Change from One Plan to Another: No

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

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

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

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

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

VA Exception for Cancellation

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

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

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

FEDVIP enrollees can verify if they are paying their premiums on a pre-or post-tax basis by contacting BENEFEDS at 1-877-888-3337, TTY:711 International: 1-571-730-5942.

When Coverage Stops

Coverage ends for active and retired Federal, U.S. Postal employees, and TRICARE-eligible individuals when you:

- no longer meet the definition of an eligible employee, annuitant, or TRICARE-eligible individual;
- as a Retired Reservist you begin active duty;
- as sponsor or primary enrollee leaves active duty
- begin a period of non-pay status or pay that is insufficient to have your FEDVIP premiums withheld and you do not make direct premium payments to BENEFEDS;
- are making direct premium payments to BENEFEDS and you stop making the payments;
- cancel the enrollment during open season;
- a Retired Reservist begins active duty; or
- the sponsor or primary enrollee leaves active duty.

Coverage for a family member ends when:

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

Continuation of Coverage

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

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

FSAFEDS/High Deductible Health Plans and FEDVIP

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

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

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

Current FSAFEDS participants must re-enroll to participate in the program next year.

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

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

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation	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 1-877-842-3625. You may also request replacement cards through www.EmblemHealth.com/fedvip-dental the EmblemHealth website. It is important to bring your FEDVIP and FEHB/PSHB identification cards to every dental appointment because most FEHB/PSHB 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	When you get care from “plan providers" you 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/fedvip-dental or you may call us at 1-877-842-3625.
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 at the out of network allowance. You are responsible for paying the provider the difference between EmblemHealth's Preferred Fee Allowance reimbursement and the non-network providers charge for covered services. The Preferred Schedule of Allowance is the amount we pay our in-network, participating dentists.
Alternate Benefit	If more than one service or procedure can be used to treat the covered person’s dental condition, EmblemHealth may decide to authorize coverage only for the less costly covered service or procedure when that service is an appropriate method of treatment and the service meets broadly accepted national standards of dental practice. The alternate benefit could result in additional out-of-pocket expense.
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, endodontics, periodontics, orthodontics, implants and other expensive treatments. Pre-certifications are also recommended for treatment costing $300 or more.
FEHB/PSHB First Payor	When you visit a provider who participates with both, your FEHB/PSHB plan and your FEDVIP plan, the FEHB/PSHB plan will pay benefits first. The FEDVIP plan allowance will be the prevailing charge in these cases. You are responsible for the difference between the FEHB/PSHB and FEDVIP benefit payments and the FEDVIP plan allowance. We are responsible for facilitating the process with the FEHB/PSHB first payor. It is important to bring your FEDVIP and FEHB/PSHB identification cards to every dental appointment because most FEHB/PSHB 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 and 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.gov or call 1-877-888-FEDS (1-877-888-3337), TTY:711 International: 1-571-730-5942 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	High Option: EmblemHealth pays 100% of the Preferred Premier plan allowances to the EmblemHealth network provider for covered services. The Preferred Premier plan allowance is the amount we pay our in-network participating dentists in the EmblemHealth Preferred Premier Network. Standard Option: EmblemHealth pays 100% of the Preferred plan allowances to the EmblemHealth network provider for covered services. The Preferred plan allowance is the amount we pay our in-network participating dentists in the EmblemHealth Preferred Network. Providers may charge members additional fees for enhanced services and/or upgraded materials.
Out-of-Network Services	Member must pay the difference of the EmblemHealth Preferred plan allowances and the dentist's normal charges. The Preferred plan allowance is the amount we pay our in-network participating dentists in the EmblemHealth Preferred Network for covered services.
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.
In-Progress Treatment	In-progress treatment for dependents of retiring active duty service members who were enrolled in the TRICARE Dental Program (TDP) will be covered for the 2027 plan year; regardless of any current plan exclusion for care initiated prior to the enrollee's effective date. This requirement includes assumption of payments for covered orthodontia services up to the FEDVIP policy limits, and full payment where applicable up to the terms of FEDVIP policy for covered services completed (but not initiated) in the 2027 plan year such as crowns and implants.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary 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.
- The following list of services includes those services most commonly provided to covered individuals and may not be an all-inclusive list of covered services. Please request a predetermination of benefits or reach out to EmblemHealth directly if you have any questions regarding treatment coverage.

You Pay:

- **High Option:** EmblemHealth pays 100% of the Preferred Premier plan allowances to the EmblemHealth network provider for covered services. The Preferred Premier plan allowance is the amount we pay our in-network participating dentists in the EmblemHealth Preferred Premier Network.
- **Standard Option:** EmblemHealth pays 100% of the Preferred plan allowances to the EmblemHealth network provider for covered services. The Preferred plan allowance is the amount we pay our in-network participating dentists in the EmblemHealth Preferred Network.
- **Out-of-Network:** EmblemHealth reimburses you 100% of the Preferred plan allowances for the covered Basic Services. The Preferred plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Network. 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 - established patient – *Limited to two in each calendar year.*

D0140 Limited oral evaluation – problem focused – *Limited to one in each calendar year.*

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver

D0150 Comprehensive oral evaluation - new or established patient – *Limited to one per calendar year per provider per lifetime.*

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

D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit)

D0180 Comprehensive periodontal evaluation - new or established patient – *Limited to one per calendar year per provider per lifetime.*

D0210 Intraoral – comprehensive series of radiographic images – *Limited to one D0210 Intraoral – comprehensive series of radiographic images or 14 periapical radiographs (from codes: D0220 Intraoral - periapical first radiographic image and D0230 Intraoral - periapical each additional radiographic image) or one D0330 Panoramic radiographic image every 36 consecutive months*

D0220 Intraoral - periapical first radiographic image - *Limited to 14 periapical radiographs in a 36-month period combined with D0230 Intraoral - periapical each additional radiographic image or one D0210 Intraoral - comprehensive series of radiographic images or one D0330 Panoramic radiographic image every 36 consecutive months*

D0230 Intraoral - periapical each additional radiographic image - *Limited to 14 periapical radiographs in a 36-month period combined with D0220 Intraoral - periapical first radiographic image or one D0210 Intraoral - comprehensive series of radiographic images or one D0330 Panoramic radiographic image every 36 consecutive months*

D0240 Intraoral - occlusal radiographic image - *Limited to two every 36 consecutive months.*

Diagnostic and Treatment Services - continued on next page

Diagnostic and Treatment Services (cont.)
D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector
D0251 Extra-oral posterior dental radiographic image
D0270 Bitewing - single radiographic image – *Limited to four bitewing x-rays in each calendar year.*
D0272 Bitewings - two radiographic images – *Limited to four bitewing x-rays in each calendar year.*
D0273 Bitewings - three radiographic images – *Limited to four bitewing x-rays in each calendar year.*
D0274 Bitewings - four radiographic images – *Limited to four bitewing x-rays in each calendar year.*
D0277 Vertical bitewings - 7 to 8 radiographic images – *Limited to four bitewing x-rays in each calendar year.*
D0321 Other temporomandibular joint radiographic images, by report
D0330 Panoramic radiographic image – *Limited to one D0210 Intraoral – comprehensive series of radiographic images or one D0330 Panoramic radiographic image every 36 consecutive months.*
D0340 2D cephalometric radiographic image - acquisition, measurement and analysis
D0502 Other oral pathology procedures, by report
D0999 Unspecified diagnostic procedure, by report
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 Application of medicament - topical fluoride varnish; full mouth – *Limited to two treatments of D1206 Application of medicament - topical fluoride varnish; full mouth or D1208 Application of medicament - topical fluoride - excluding varnish; full mouth in 12 consecutive months, to age 19.*
D1208 Application of medicament - topical fluoride - excluding varnish; full mouth – *Limited to two treatments of D1206 Application of medicament - topical fluoride varnish; full mouth or D1208 Application of medicament - topical fluoride - excluding varnish; full mouth in 12 consecutive months, to age 19.*
D1351 Sealant – per tooth – *Limited to permanent molars to age 18. One sealant per tooth in a 3-year period*
D1510 Space maintainer - fixed, unilateral – per quadrant – *Limited to one space maintainer per quadrant per covered dependent child per lifetime. Eligible until the end of the calendar year in which the child reaches 19.*
D1516 Space maintainer – fixed – bilateral, maxillary – *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.*
D1517 Space maintainer – fixed – bilateral, mandibular – *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.*
D1520 Space maintainer - removable, unilateral - per quadrant – *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.*
D1526 Space maintainer – removable – bilateral, maxillary – *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.*
D1527 Space maintainer – removable – bilateral, mandibular – *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.*
D1551 Re-cement or re-bond bilateral space maintainer - maxillary - *Eligible until the end of the calendar year in which the child reaches 19.*
D1552 Re-cement or re-bond bilateral space maintainer - mandibular - *Eligible until the end of the calendar year in which the child reaches 19.*
D1553 Re-cement or re-bond unilateral space maintainer - per quadrant - *Eligible until the end of the calendar year in which the child reaches 19.*
D1575 Distal shoe space maintainer - fixed, unilateral - per quadrant
D1999 Unspecified preventive procedure, by report

Additional Procedures covered as Basic Services

D9110 Palliative treatment of dental pain – per visit – *Limited to one palliative service for each member in each calendar year.*

Limitations:

EmblemHealth will allow a combination of two routine examinations along with one limited emergency examination within a 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.
- The following list of services includes those services most commonly provided to covered individuals and may not be an all-inclusive list of covered services. Please request a predetermination of benefits or reach out to EmblemHealth directly if you have any questions regarding treatment coverage.

You Pay:

- **High Option:** EmblemHealth pays 100% of the Preferred Premier plan allowances to the EmblemHealth network provider for covered services. The Preferred Premier plan allowance is the amount we pay our in-network participating dentists in the EmblemHealth Preferred Premier Network.
- **Standard Option:** EmblemHealth pays 100% of the Preferred plan allowances to the EmblemHealth network provider for covered services. The Preferred plan allowance is the amount we pay our in-network participating dentists in the EmblemHealth Preferred Network. Providers may charge members additional fees for enhanced services and/or upgraded materials.
- **Out-of-Network:** After you meet the annual deductible, EmblemHealth reimburses you 100% of the Preferred plan allowances for the covered Intermediate services listed below. The Preferred plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Network. 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 (anterior)
D2391 Resin-based composite - one surface, posterior – *Pre-molars only*
D2392 Resin-based composite - two surfaces, posterior – *Pre-molars only*
D2393 Resin-based composite - three surfaces, posterior – *Pre-molars only*
D2394 Resin-based composite - four or more surfaces, posterior – *Pre-molars only*
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration
D2920 Re-cement or re-bond crown
D2950 Core buildup, including any pins when required - *Limited to once per tooth in a 5 year period*
D2951 Pin retention – per tooth, in addition to restoration
D2980 Crown repair necessitated by restorative material failure

Minor Restorative Services - continued on next page

Minor Restorative Services (cont.)

Not Covered:

- *Restorations, including veneers, which are placed for cosmetic purposes only*
- *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 twelve (12) month period. EmblemHealth will not pay more than this maximum benefit for fillings for each Member in any twelve (12) month period.*
- *If two (2) fillings are done on the same posterior tooth on the same day, EmblemHealth'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) - removal of pulp coronal to the dentinocemental junction and application of medicament

D3221 Pulpal debridement, primary and permanent teeth

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) – *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.*

D3310 Endodontic therapy, anterior tooth (excluding final restoration)

D3320 Endodontic therapy, premolar tooth (excluding final restoration)

D3330 Endodontic therapy, molar tooth (excluding final restoration)

D3346 Retreatment of previous root canal therapy - anterior

D3347 Retreatment of previous root canal therapy - premolar

D3348 Retreatment of previous root canal therapy - molar

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

D3352 Apexification/recalcification – interim medication replacement

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

D3410 Apicoectomy - anterior

D3421 Apicoectomy - premolar (first root)

D3425 Apicoectomy - molar (first root)

D3426 Apicoectomy (each additional root)

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 tooth bounded spaces per quadrant

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

D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant

D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant

D4249 Clinical crown lengthening – hard tissue - *Covered only when performed by a specialist*

D4260 Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant - *Limited to once every 24 consecutive months.*

D4261 Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant - *Limited to once every 24 consecutive months.*

Periodontal Services - continued on next page

Periodontal Services (cont.)
D4270 Pedicle soft tissue graft procedure
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4341 Periodontal scaling and root planing - four or more teeth per quadrant - *Limited to once every 36 consecutive months.*
D4342 Periodontal scaling and root planing - one to three teeth per quadrant - *Limited to once every 36 consecutive months.*
D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation
D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - *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
D5511 Repair complete denture base, mandibular
D5512 Repair complete denture base, maxillary
D5520 Replace missing or broken teeth – complete denture – per tooth
D5611 Repair resin partial denture base, mandibular
D5612 Repair resin partial denture base, maxillary
D5621 Repair cast partial framework, mandibular
D5622 Repair cast partial framework, maxillary
D5630 Repair or replace broken retentive clasping materials – per tooth
D5640 Replace missing or broken teeth – partial denture – per tooth
D5650 Add tooth to existing partial denture – per tooth
D5660 Add clasp to existing partial denture - per tooth
D5710 Rebase complete maxillary denture
D5720 Rebase maxillary partial denture
D5721 Rebase mandibular partial denture
D5730 Reline complete maxillary denture (direct)
D5731 Reline complete mandibular denture (direct)
D5740 Reline maxillary partial denture (direct)
D5741 Reline mandibular partial denture (direct)
D5750 Reline complete maxillary denture (indirect)
D5751 Reline complete mandibular denture (indirect)
D5760 Reline maxillary partial denture (indirect)
D5761 Reline mandibular partial denture (indirect)
D6930 Re-cement or re-bond fixed partial denture
D6980 Fixed partial denture repair necessitated by restorative material failure

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)

Limitations:

- Rebase or reline to a denture is limited to one (1) per denture in a 3-year period.

Not Covered:

- Denture rebase or repair within six months of the insertion date of a new denture.

Implant Services

Please see Class C Implant Services for a full description of the implant benefits.

D6089 Accessing and retorquing loose implant screw - per screw

D6092 Re-cement or re-bond implant/abutment supported crown

D6093 Re-cement or re-bond implant/abutment supported fixed partial denture

Oral Surgery

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

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated

D7220 Removal of impacted tooth – soft tissue

D7230 Removal of impacted tooth – partially bony

D7240 Removal of impacted tooth – completely bony

D7250 Removal of residual tooth roots (cutting procedure)

D7251 Coronectomy – intentional partial tooth removal, impacted teeth only

D7270 Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth

D7280 Exposure of an unerupted tooth

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

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

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

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

D7471 Removal of lateral exostosis (maxilla or mandible)

D7510 Incision and drainage of abscess – intraoral soft tissue

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.
- The following list of services includes those services most commonly provided to covered individuals and may not be an all-inclusive list of covered services. Please request a predetermination of benefits or reach out to EmblemHealth directly if you have any questions regarding treatment coverage.

You Pay:

- **High Option:** EmblemHealth pays 100% of the Preferred Premier plan allowances to the EmblemHealth network provider for covered services. The Preferred Premier plan allowance is the amount we pay our in-network participating dentists in the EmblemHealth Preferred Premier Network.
- **Standard Option:** EmblemHealth pays 100% of the Preferred plan allowances to the EmblemHealth network provider for covered services. The Preferred plan allowance is the amount we pay our in-network participating dentists in the EmblemHealth Preferred Network. Providers may charge members additional fees for enhanced services and/or upgraded materials.
- **Out-of-Network:** After you meet the annual deductible, EmblemHealth reimburses you 100% of the Preferred plan allowances for the covered Major services listed below. The Preferred plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Network. 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

D2542 Onlay - metallic - two surfaces
D2543 Onlay - metallic - three surfaces
D2544 Onlay - metallic - four or more surfaces
D2740 Crown - porcelain/ceramic
D2750 Crown - porcelain fused to high noble metal
D2751 Crown - porcelain fused to predominantly base metal
D2752 Crown - porcelain fused to noble metal
D2780 Crown - 3/4 cast high noble metal
D2781 Crown - 3/4 cast predominantly base metal
D2783 Crown - 3/4 porcelain/ceramic
D2790 Crown - full cast high noble metal
D2791 Crown - full cast predominantly base metal
D2792 Crown - full cast noble metal
D2794 Crown - titanium and titanium alloys
D2930 Prefabricated stainless steel crown - primary tooth – *Limited to once per tooth in a 5 year period*
D2931 Prefabricated stainless steel crown – permanent tooth – *Limited to once per tooth in a 5 year period*
D2954 Prefabricated post and core in addition to crown - *Limited to once per tooth in a 5 year period*

Major Restorative Services - continued on next page

Major Restorative Services (cont.)

Not covered:

- *Sedative restorations*
- *Restorations for cosmetic purposes only*
- *Composite resin inlays*
- *Temporary crowns*
- *Precision attachments, personalization, precious metal bases, and other specialized techniques*
- *Removable or fixed prostheses initiated prior to the effective date of coverage or inserted/cemented after the coverage ending date*

Limitations:

- *EmblemHealth will pay the allowance for restorative crowns only if the tooth cannot otherwise be restored.*
- *EmblemHealth reimburses crowns other than porcelain fused to predominantly base metal at the allowance for predominantly base metal for the Standard option.*
- *When restorative crowns are made from upgraded materials, members are responsible for the difference between the dentist's charge and the Preferred plan's allowance.*
- *Class C major restorative services are only covered once every five (5) years per tooth.*

Prosthodontic Services

D5110 Complete denture - maxillary
D5120 Complete denture - mandibular
D5130 Immediate denture - maxillary
D5140 Immediate denture - mandibular
D5211 Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)
D5212 Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5282 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary
D5283 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular
D6210 Pontic - cast high noble metal
D6211 Pontic - cast predominantly base metal
D6212 Pontic - cast noble metal
D6214 Pontic - titanium and titanium alloys
D6240 Pontic - porcelain fused to high noble metal
D6241 Pontic - porcelain fused to predominantly base metal
D6242 Pontic - porcelain fused to noble metal
D6245 Pontic - porcelain/ceramic
D6545 Retainer - cast metal for resin bonded fixed prosthesis
D6740 Retainer crown - porcelain/ceramic
D6750 Retainer crown - porcelain fused to high noble metal
D6751 Retainer crown - porcelain fused to predominantly base metal
D6752 Retainer crown - porcelain fused to noble metal
D6780 Retainer crown - 3/4 cast high noble metal

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)

D6781 Retainer crown - 3/4 cast predominantly base metal

D6782 Retainer crown - 3/4 cast noble metal

D6783 Retainer crown - 3/4 porcelain/ceramic

D6790 Retainer crown - full cast high noble metal

D6791 Retainer crown - full cast predominantly base metal

D6792 Retainer crown - full cast noble metal

Not covered:

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

Limitations:

- *Removable or fixed prostheses initiated prior to the effective date of coverage or inserted/cemented after the coverage ending date. EmblemHealth will pay the allowance for fixed bridge crowns only if the tooth cannot otherwise be restored.*
- *EmblemHealth reimburses fixed bridge crowns and pontics other than porcelain fused to predominantly base metal at the allowance for predominantly base metal for the Standard option.*
- *Each crown and pontic in a fixed bridge is counted as a separate unit.*
- *When fixed bridge crowns and pontics are made from upgraded materials, members are responsible for the difference between the dentist's charge and the Preferred plan's allowance.*
- *Class C major prosthodontic services are only covered once every five (5) years per tooth or per arch.*

Implant Services

Important things you should keep in mind about these benefits:

- Implant coverage is subject to clinical and benefit limitations. EmblemHealth strongly suggests your dentist submit a predetermination of benefits prior to treatment.
- There is a calendar year deductible for Implant services out of network (see page 20).
- The annual allowance for the surgical placement of the implant is:
  - High Option: $4,500
  - Standard Option: $3,000

You Pay:

High and Standard Options:

- **In-Network**:
  - High option plan, EmblemHealth will issue payment of $1,800 per surgical placement of the implant up to the annual maximum of $4,500. If the maximum is met, the member is only responsible up to the fee of $1,800 which EmblemHealth would have paid.
  - Standard option plan, EmblemHealth will issue payment up to the provider’s charges up to $3,000 per year for the surgical placement of the implant. For any remaining balance, the member is responsible for paying the provider’s full charge**.** Providers may charge members additional fees for enhanced services and/or upgraded materials.
- **Out-of-Network**: EmblemHealth will issue payment directly to the member for out of network claims payments.

Implant Services - continued on next page

Implant Services (cont.)
D6010 Surgical placement of implant body: endosteal implant - *Limited to once per tooth per lifetime*
D6058 Abutment supported porcelain/ceramic crown
D6059 Abutment supported porcelain fused to metal crown (high noble metal)
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061 Abutment supported porcelain fused to metal crown (noble metal)
D6064 Abutment supported cast metal crown (noble metal)
D6065 Implant supported porcelain/ceramic crown
D6068 Abutment supported retainer for porcelain/ceramic FPD
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6075 Implant supported retainer for ceramic FPD
D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys

Not covered:

- *Sinus augmentation*
- *Cone beam images*
- *Implant replacements*
- *Bone grafts*
- *Periodontal services related to implants*
- *Implant abutments*
- *Implants on wisdom teeth (tooth numbers 1, 16, 17, 32)*
- *Removal or reimplantation of an implant*
- *Temporary services*

Limitations:

- *Submitted diagnostics must support the prospect for a successful implant.*
- *Replacement or substitution of single crowns and fixed bridges over implants are only covered after five (5) years per tooth have passed since the appliance was inserted.*
- *When implant crowns and implant fixed bridges are made from upgraded materials, members are responsible for the difference between the dentist's charge and the Preferred plan's allowance.*
- *EmblemHealth reimburses crowns over implants at the allowance for single crowns, predominantly base metal for the Standard option.*

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.
- There is no waiting period.
- The lifetime maximum for orthodontic services is:
  - High Option: $4,000
  - Standard Option: $3,000.
- The annual benefit maximum does not apply to Orthodontic services.
- Orthodontia coverage is for both adults and children.
- The following list of services includes those services most commonly provided to covered individuals and may not be an all-inclusive list of covered services. Please request a predetermination of benefits or reach out to EmblemHealth directly if you have any questions regarding treatment coverage.

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. EmblemHealth will pay the provider as per the Preferred Premier plan allowances. The Preferred Premier plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Premier Network.

Standard 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. EmblemHealth will pay the provider as per the Preferred plan allowances. The Preferred plan allowance is the amount we pay our participating dentists in the EmblemHealth Preferred Network.

High and Standard Options

- **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 Preferred plan allowance reimbursement and the non-network provider's charge for services. The Preferred plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Network.

Orthodontic Services
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of the adult dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition
D8670 Periodic orthodontic treatment visit
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))

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.
- The following list of services includes those services most commonly provided to covered individuals and may not be an all-inclusive list of covered services. Please request a predetermination of benefits or reach out to EmblemHealth directly if you have any questions regarding treatment coverage.

You Pay:

- **High Option:** EmblemHealth pays 100% of the Preferred Premier plan allowances to the EmblemHealth network provider for covered services. The Preferred Premier plan allowance is the amount we pay our in-network participating dentists in the EmblemHealth Preferred Premier Network.
- **Standard Option:** EmblemHealth pays 100% of the Preferred plan allowances to the EmblemHealth network provider for covered services. The Preferred plan allowance is the amount we pay our in-network participating dentists in the EmblemHealth Preferred Network.
- **Out-of-Network:** After you meet the annual deductible, EmblemHealth reimburses you 100% of the Preferred plan allowances for the covered General services listed below. The Preferred plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Network. 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

D9222 Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof

D9223 Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof

Intravenous Sedation

D9239 Administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof

D9243 Administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof

Consultations

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician

Office Visits

D9410 House/extended care facility call

D9420 Hospital or ambulatory surgical center call

D9430 Office visit for observation (during regularly scheduled hours) - no other services performed

D9440 Office visit - after regularly scheduled hours

Post Surgical Services
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report
Miscellaneous Services
D9941 Fabrication of athletic mouthguard - *Limited to one per 12 month period*
D9944 Occlusal guard - hard appliance, full arch
D9945 Occlusal guard - soft appliance, full arch
D9946 Occlusal guard - hard appliance, partial arch
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 claims to:** 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 1-877-842-3625, or visit us at www.EmblemHealth.com/fedvip-dental

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 their 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 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 ADA 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, 55 Water St, New York, NY 10041; 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, flouride treatments, sealants, space maintainers, palliative treatments and x-rays.
Class B Services	Intermediate services, which include minor restorative procedures such as fillings, endodontic services such as root canals, periodontal services such as gingivectomy, tooth extractions, and prosthetic repairs such as denture adjustments.
Class C Services	Major services, which include major restorative services such as crowns and onlays, implant services, fixed bridges and dentures.
Class D Services	Orthodontic services.
Enrollee	The Federal employee, annuitant, or TRICARE-eligible individual enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Generally Accepted Dental Protocols	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.
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 before you can receive services.
Sponsor	Generally, a sponsor means the individual who is eligible for medical or dental benefits under 10 U.S.C. chapter 55 based on their direct affiliation with the uniformed services (including military members of the National Guard and Reserves).
TEI certifying family member	Under circumstances where a sponsor is not an enrollee, a TEI family member may accept responsibility to self-certify as an enrollee and enroll TEI family members.

TRICARE-eligible individual (TEI) family member	TEI family members include a sponsor's spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in a sponsor's legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.
We/Us	EmblemHealth
You	Enrollee or eligible family member.
In-Progress Treatment	Dental services that initiated in 2026 that will be completed in 2027.

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 1-877-842-3625 and explain the situation.
- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless they are disabled and incapable of self- support).

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

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

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

Summary of Benefits

- **Do not rely on this chart alone.** This page summarizes specific expenses we cover; for more detail, please review the individual sections of this brochure.

  If you want to enroll or change your enrollment in this plan, please visit www. BENEFEDS.gov or call 1-877-888-FEDS (1-877-888-3337), TTY:711 International: 1-571-730-5942.

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

Benefits	You Pay	
Network Benefits	**High Option**	**Standard Option**
Class A (Basic) Services – preventive and diagnostic	In-Network: Nothing. EmblemHealth pays 100% of the Preferred Premier plan allowances to the EmblemHealth provider for covered services. The Preferred Premier plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Premier Network. Out-of-Network: EmblemHealth will reimburse you 100% of the Preferred plan allowances. The Preferred plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Network. You are responsible for paying the provider the difference between EmblemHealth's reimbursement and the non-network provider's charge for covered service.	In-Network: Nothing. EmblemHealth pays 100% of the Preferred plan allowances to the EmblemHealth provider for covered services. The Preferred plan allowance is the amount we pay our in-network, participating providers in the EmblemHealth Preferred Network. Out-of-Network: EmblemHealth will reimburse you 100% of the Preferred plan allowances. The Preferred plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Network. You are responsible for paying the provider the difference between EmblemHealth's reimbursement and the non-network provider's charge for covered service.
Class B (Intermediate) Services – includes minor restorative, endodontics, periodontics, prosthetic repairs and oral surgical services.	In-Network: Nothing. EmblemHealth pays 100% of the Preferred Premier plan allowances to the EmblemHealth provider for covered services. The Preferred Premier plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Premier Network.	In-Network: Nothing. EmblemHealth pays 100% of the Preferred plan allowances to the EmblemHealth provider for covered services. The Preferred Premier plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Premier Network.

Network Benefits - continued on next page

Benefits	You Pay	
Network Benefits (cont.)	**High Option**	**Standard Option**
	Out-of-Network: *After you meet the annual deductible, EmblemHealth will reimburse you 100% of the Preferred plan allowances. The Preferred plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Network. You are responsible for paying the provider the difference between EmblemHealth's reimbursement and the non-network provider's charge for covered service.	Out-of-Network: *After you meet the annual deductible, EmblemHealth will reimburse you 100% of the Preferred plan allowances. The Preferred plan alllowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Network. You are responsible for paying the provider the difference between EmblemHealth's reimbursement and the non-network provider's charge for covered service. Dentists may charge members additional fees for enhanced materials.
Class C (Major) Services – includes major restorative, implant, and prosthodontic services	In-Network: Nothing. EmblemHealth pays 100% of the Preferred Premier plan allowances to the EmblemHealth provider for covered services. The Preferred Premier plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Premier Network. Out-of-Network: *After you meet the annual deductible, EmblemHealth will reimburse you 100% of the Preferred plan allowances. The Preferred plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Prreferred Network. You are responsible for paying the provider the difference between EmblemHealth's reimbursement and the non-network provider's charge for covered service.	In-Network: Nothing. EmblemHealth pays 100% of the Preferred plan allowances to the EmblemHealth provider for covered services. The Preferred plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Network. Out-of-Network: *After you meet the annual deductible, Emblemhealth will reimburse you 100% of the Preferred plan allowances. The Preferred plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Network. You are responsible for paying the provider the difference between EmblemHealth's reimbursement and the non-network provider's charge for covered service. Dentists may charge members additional fees for enhanced materials.
Class A, B, and C Services are subject to an unlimited annual maximum benefit	Subject to an unlimited annual maximum benefit	Subject to an unlimited annual maximum benefit

Network Benefits - continued on next page

Benefits	You Pay	
Network Benefits (cont.)	**High Option**	**Standard Option**
Class D Services – orthodontic High Option: $4,000 Lifetime Maximum Standard Option: $3,000 Lifetime Maximum	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. EmblemHealth pays the provider the Preferred Premier plan allowances for covered services. The Preferred Premier plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Premier Network.	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. EmblemHealth pays the provider the Preferred Premier plan allowances for covered services. The Preferred Premier plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Premier Network.
	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 Preferred plan allowance reimbursement and the non-network provider's charge for services. The Preferred plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Network.	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 Preferred plan allowance reimbursement and the non-network provider's charge for services. The Preferred plan allowance is the amount we pay our in-network, participating dentists in the EmblemHealth Preferred Network.

Network Benefits - continued on next page

Benefits	You Pay	
Network Benefits (cont.)	**High Option**	**Standard Option**
Implants - High Option: $4,500 Annual Allowance Standard Option: $3,000 Annual Allowance	In-Network: EmblemHealth pays 100% of Preferred Premier plan allowance for surgical placement of the implant up to the allowed amount. Out-of-Network: EmblemHealth will issue payment directly to the member for out-of-network claims. *After you meet the annual deductible, Emblemhealth will reimburse you 100% of the Preferred plan allowances. The Preferred plan allowance is the amount we pay our in-network, participating dentists. You are responsible for paying the provider the difference between EmblemHealth's reimbursement and the non-network provider's charge for covered service.	In-Network: EmblemHealth pays 100% of Preferred plan allowance for placement of the implant up to the provider's charge. Out-of-Network: EmblemHealth will issue payment directly to the member for out-of-network claims. *After you meet the annual deductible, Emblemhealth will reimburse you 100% of the Preferred plan allowances. The Preferred plan allowance is the amount we pay our in-network, participating dentists. You are responsible for paying the provider the difference between EmblemHealth's reimbursement and the non-network provider's charge for covered service. Dentists may charge members additional fees for enhanced materials.

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2027 Rate Information

Bi-weekly & Monthly Rates

High - Bi-Weekly			High - Monthly		
Self Only	**Self Plus One**	**Self and Family**	**Self Only**	**Self Plus One**	**Self and Family**
$34.48	**$68.88**	**$103.37**	**$74.71**	**$149.24**	**$223.97**

Standard - Bi-Weekly			Standard - Monthly		
Self Only	**Self Plus One**	**Self and Family**	**Self Only**	**Self Plus One**	**Self and Family**
$21.16	**$42.29**	**$63.46**	**$45.85**	**$91.63**	**$137.50**