BlueCross BlueShield
Federal Employee Program

Federal DentalBlue

Standard and Basic Options

Effective January 1, 2020

Federal DentalBlue – Standard Option 2020

Benefit	Coverage
Deductible	There is no deductible.
Maximum	$1,750 per member each calendar year.
Diagnostic and Preventive	**Payable at 100% of the PPO Fee Schedule with no deductible.** • Dental exams, twice per calendar year.* • Dental X-ray exams: Full mouth x-rays, one set during any 36 months in a row;* Bitewing x-rays, up to twice per benefit period;* and Other dental x-rays, used to diagnose a specific condition. • Routine cleaning, twice per calendar year.* • Tooth sealants on teeth numbers 3, 14, 19 and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of $20.00 per tooth. Limited to the first permanent molars of children through age 13. • Topical Fluoride treatment twice per calendar year for members through age 12 (no adult fluoride treatments). • Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18. • Sedative fillings. • Pulp vitality tests. • Emergency treatment for pain.* * **These services are covered under your Standard Option medical benefits. Refer to your 2020 Service Benefit Plan brochure for specific dental limitations.**
Basic Restorative Services	**Payable at 80% of the PPO Fee Schedule with no deductible.** • Fillings made of silver amalgam and synthetic tooth color materials • Pin retention • Simple tooth extractions • Surgical tooth extractions of erupted teeth • General anesthesia when necessary and when rendered in connection with covered dental surgery
Endodontics, Periodontics and Major Restorative Prosthodontics and Related Services	**Payable at 50% of the PPO Fee Schedule with no deductible.** • Treatment of the root tip of the tooth including its removal, once per 36 months. • Direct pulp capping, once per 36 months. • Pulpotomy, once per tooth per lifetime. • Root canal therapy, once per tooth per lifetime. • Full or partial dentures, including adjustments and relining 6 months after initial placement and repair, once per tooth per year. • Fixed or removable bridges. Recementing of bridge twice per tooth per lifetime, and repair-once per tooth per year after cemented in place for 6 months. • Inlays, onlays or crowns (including recementing). Recementing covered once per tooth per year. • Stainless steel crowns for deciduous teeth or 1st permanent molars for members under age 16. • Periodontic maintenance after active treatment, 4 times per calendar year. • Free soft tissue graft, including donor site, once per 36 months. • Gingival flap procedure, once per 36 months. • Osseous surgery, once per 36 months. • Scaling and root planing, once per quadrant per 24 months. **Note: No benefits are available for expenses involving the replacement of teeth that were missing prior to the effective date of the contract. This exclusion will not apply after a member is enrolled in the contract for 24 consecutive months.**

This is not a contract. Benefits are subject to the terms, limitations and conditions of the contract. 9/2019 RM

For complete details on Federal DentalBlue Standard Option benefits, definitions, limitations and exclusions, please read the Federal DentalBlue Standard Option Certificate of Benefits.

Benefits for covered services received from an out-of-network dentist are provided at the same level as would have been provided with a Preferred network dentist up to the maximum amount of your coverage. If an out-of-network dentist charges more than the Maximum Allowable Charge (MAC), you are responsible for the balance.

2020 Federal DentalBlue Standard Option Rates for the Alabama Plan Area

Self Only $31.00 (Monthly)	**Self + One** $58.00 (Monthly)	**Self and Family** $65.00 (Monthly)

Federal DentalBlue – Basic Option 2020

Benefit	Coverage
Deductible	There is no deductible.
Maximum	$1,750 per member each calendar year.
Enhanced Diagnostic and Preventive	**Payable at 100% of the PPO Fee Schedule with no deductible.** • Dental exams, twice per calendar year.* • Dental X-ray exams: Full mouth x-rays, one set during any 36 months in a row;* Bitewing x-rays, up to twice per benefit period;* and Other dental x-rays, used to diagnose a specific condition. • Routine cleaning, twice per calendar year.* • Tooth sealants on teeth numbers 3, 14, 19 and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of $20.00 per tooth. Limited to the first permanent molars of children through age 13.* • Topical Fluoride treatment twice per calendar year for members through age 12 (no adult fluoride treatments).* • Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18. • Sedative fillings. • Pulp vitality tests. • Emergency treatment for pain. * **These services are covered under your Basic Option medical benefits with dental exams subject to a $30 copay when you use a Preferred network dentist. Refer to your 2020 Service Benefit Plan brochure for specific dental limitations.**
Basic Restorative Services	**Payable at 80% of the PPO Fee Schedule with no deductible.** • Fillings made of silver amalgam and synthetic tooth color materials • Pin retention • Simple tooth extractions • Surgical tooth extractions of erupted teeth • General anesthesia when necessary and when rendered in connection with covered dental surgery
Endodontics, Periodontics and Major Restorative Prosthodontics and Related Services	**Payable at 50% of the PPO Fee Schedule with no deductible.** • Treatment of the root tip of the tooth including its removal, once per 36 months. • Direct pulp capping, once per 36 months. • Pulpotomy, once per tooth per lifetime. • Root canal therapy, once per tooth per lifetime. • Full or partial dentures, including adjustments and relining 6 months after initial placement and repair, once per tooth per year. • Fixed or removable bridges. Recementing of bridge twice per tooth per lifetime, and repair-once per tooth per year after cemented in place for 6 months. • Inlays, onlays or crowns (including recementing). Recementing covered once per tooth per year. • Stainless steel crowns for deciduous teeth or 1st permanent molars for members under age 16. • Periodontic maintenance after active treatment, 4 times per calender year. • Free soft tissue graft, including donor site, once per 36 months. • Gingival flap procedure, once per 36 months. • Osseous surgery, once per 36 months. • Scaling and root planing, once per quadrant per 24 months. **Note: No benefits are available for expenses involving the replacement of teeth that were missing prior to the effective date of the contract. This exclusion will not apply after a member is enrolled in the contract for 24 consecutive months.**

This is not a contract. Benefits are subject to the terms, limitations and conditions of the contract. 9/2019 RM

For complete details on Federal DentalBlue Basic Option benefits, definitions, limitations and exclusions, please read the Federal DentalBlue Basic Option Certificate of Benefits.

Benefits for covered services received from an out-of-network dentist are provided at the same level as would have been provided with a Preferred network dentist up to the maximum amount of your coverage. If an out-of-network dentist charges more than the Maximum Allowable Charge (MAC), you are responsible for the balance.

2020 Federal DentalBlue Basic Option Rates for the Alabama Plan Area

Self Only $20.00 (Monthly)	**Self + One** $37.00 (Monthly)	**Self and Family** $43.00 (Monthly)

Federal DentalBlue – Standard and Basic Option Information

As long as you remain eligible for enrollment in Federal DentalBlue, your enrollment period is for the entire calendar year. The Federal DentalBlue benefits are based on year-long premiums. For federal employees hired in the middle of a calendar year, the enrollment period and total premium liability are determined based on the effective date of enrollment. **If you cancel your Federal DentalBlue coverage to enroll in a dental plan other than the national FEP BlueDental plan, you will not be able to re-enroll in Federal DentalBlue during the next three Open Seasons**.

If you have FEHB Standard or Basic Option "Self Only" coverage, you must elect Alabama Federal DentalBlue "Self Only" coverage. If you have FEHB Standard or Basic Option "Self + One" coverage, you must elect Alabama Federal DentalBlue "Self + One" coverage. If you have FEHB Standard or Basic Option "Self and Family" coverage, you must elect Alabama Federal DentalBlue "Self and Family" coverage.

This benefit is neither offered nor guaranteed under contract with the FEHB Program. This benefit is available to all enrollees and family members who reside in the service area for the Alabama Plan and are members of the Blue Cross and Blue Shield Service Benefit Plan's Standard or Basic Option.

Partial List of Exclusions and Limitations:

- Benefits are provided for up to $1,750 per person each year (in addition to your regular Standard Option or Basic Option benefits).
- Root canal therapy is limited to once per tooth per lifetime.
- Benefits are not provided for gingival curettage.
- Pulpotomy is limited to once per tooth per lifetime.
- Sealants are limited to the first permanent molars for children through age 13 with a $20 maximum payment per tooth.
- There is a 24-month waiting period before benefits are available for services related to missing teeth such as full dentures, partial dentures and fixed bridges.
- Diagnosis, correction and treatment of TMJ are not covered.
- Orthodontics are not covered.
- Services or procedures rendered or commencing before your dental coverage effective date are not covered.

This is not a complete description of the Federal DentalBlue Standard or Basic Option plans. Please refer to your Federal DentalBlue Certificate of Benefits for a complete explanation of benefits, definitions, exclusions and limitations.

Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-855-216-3144（TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-216-3144 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ ້າ ທ ່ ານເ ວ ົ ້ າພາສາ ລາວ, ການ ບ ໍ ລ ິ ການ ຊ ່ ວຍ ເ ຫ ຼ ືອ ດ ້ ານພາສາ, ໂດຍ ບ ່ ເ ສ ັ ຽ ຄ ່ າ, ແ ມ ່ ນ ມ ີ ພ ້ ອ ມ ໃ ຫ ້ ທ ່ ານ. ໂ ທ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。

1-800-492-8872

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