Triple-S

http://www.ssspr.com

TRIPLE-S, INC. | An Independent Licensee of the BlueCross BlueShield Association

2009

A Regional Dental PPO Plan

Serving: Puerto Rico

Enrollment Options for this Plan:

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

Enrollment in this Plan is limited. You must live in Puerto Rico to enroll.

FEDVIP
Federal Employees
Dental And Vision Insurance Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The Act directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants, and their eligible family members. In response to the legislation, OPM established the Federal Employees Dental and Vision Insurance Program (FEDVIP). OPM has contracted with dental and vision insurers to offer an array of choices to Federal employees and annuitants.

This brochure describes the benefits of Triple-S under Triple-S's contract OPM-06-00060-8 with OPM as authorized by the FEDVIP law. The address for our administrative office is:

Triple-S, Inc. (Triple-S)
1441 Roosevelt Avenue
San Juan, Puerto Rico 00920
Customer Service Phone Number: (787) 774-6060, TTY number (787) 792-1370
Web site: www.ssspr.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, 2009, unless those benefits are also shown in this brochure.

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

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

Triple-S Dental Plan is responsible for the selection of in-network providers in your area. Contact us at (787) 774-6060, TTY number (787) 792-1370 for the names of participating providers or to request a provider directory. You may also view or request the most current directory via our Web site at www.ssspr.com. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not on a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in-network. If your provider is not currently participating in the provider network, you may nominate him or her to join. Nomination forms are available on our Web site, or call us and we will have a form sent to you. You cannot change plans, outside of Open Season, because of changes to the provider network.

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

The Triple-S Plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program.

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FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide and in some areas regional, dental Preferred Provider Organizations (PPO), and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Visit www.opm.gov/insure/dental and www.opm.gov/insure/vision for more information.
Enroll Through BENEFEDS	You enroll through the Internet at www.BENEFEDS.com. Please see Section 2, Enrollment, for more information.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2008 Open Season, your coverage will begin on January 1, 2009. Premium deductions will start with the first full pay period beginning on/after January 1, 2009. You may use your benefits as soon as your enrollment is confirmed.
Pre-Tax Salary Deduction for Employees	Employees automatically pay premiums through payroll deductions using pre-tax dollars. Annuitants automatically pay premiums through annuity deductions using post-tax dollars.
Annual Enrollment Opportunity	Each year, an Open Season will be held, during which you may enroll or change your dental and/or vision plan enrollment. This year, Open Season runs from November 10, 2008 through December 8, 2008. You do not need to re-enroll each Open Season unless you wish to change plans or plan options; your coverage will continue from the previous year. In addition to the annual Open Season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2, Enrollment, for more information.
Continued Group Coverage After Retirement	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may also be able to continue enrollment after your death. Please see Section 1, Eligibility, for more information.
Waiting Period	The only waiting period is for orthodontic services. To meet this requirement, the person receiving the services must be enrolled in the same plan/option for the entire waiting period.

Section 1 Eligibility

Federal Employees

If you are a Federal or U.S. Postal Service employee, you are eligible to enroll in FEDVIP if you are eligible for the Federal Employees Health Benefits (FEHB) Program. Enrollment in the FEHB Program is not required.

Federal Annuitants

You are eligible to enroll if you:

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

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

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

Survivor Annuitants

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

Compensationers

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

Family Members

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

FEDVIP rules and FEHB rules for family member eligibility are the same. For more information on family member eligibility, see the FEHB Handbook at www.opm.gov/insure/handbook or contact your employing agency or retirement system.

Not Eligible

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

- Deferred annuitants;
- Former spouses of employees or annuitants;
- FEHB Temporary Continuation of Coverage (TCC) enrollees;
- Anyone receiving an insurable interest annuity who is not also an eligible family member.

Section 2 Enrollment

Enroll Through BENEFEDS

You must use BENEFEDS to enroll or change enrollment in a FEDVIP plan. BENEFEDS is a secure enrollment website (www.BENEFEDS.com) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not want to change plans, your enrollment will continue automatically. **Please Note:** your plans' premiums may change for 2009.

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

Enrollment Types

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

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

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

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

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee or annuitant, you may enroll in a dental and/or vision plan during the November 10 through December 8, 2008 Open Season. Coverage is effective January 1, 2009.

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

New hire/Newly eligible

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

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

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

Qualifying Life Event

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

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

Qualifying Life Event	**From Not Enrolled to Enrolled**	**INCREASE: Enrollment Type**	**DECREASE: Enrollment Type**	**Cancel**	**CHANGE: from one plan to another**
Acquiring an eligible family member	No	Yes	No	No	No
Losing a covered family member	No	No	Yes	No	No
Losing other dental/vision coverage (eligible or covered person)	Yes	Yes	No	No	No
Moving out of regional plan's service area	No	No	No	No	Yes
Going on active military duty, non-pay status*	No	No	No	Yes	No
Return to pay status from active military duty	Yes	No	No	No	No
Annuity/compensation restored	Yes	Yes	Yes	No	No

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

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

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

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

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

Canceling an enrollment

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

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

When Coverage Stops

Coverage ends when you:

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

Coverage for a family member ends when:

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

Continuation of Coverage

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

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

FSAFEDS/High Deductible Health Plans and FEDVIP

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

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

Current FSAFEDS participants must re-enroll to participate in 2009. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-800-952-0450.

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

You will be required to submit your claims on behalf of the Triple-S Dental Plan to the FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA) to claim reimbursement.

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a plan provider. Your ID card does not have an expiration date to ensure the continuity of services.

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 787-774-6060, TTY number 787-792-1370 or write to us at Triple-S, Inc. (Triple-S), Customer Service Department, 1441 Roosevelt Avenue, San Juan, Puerto Rico 00920. You may also request replacement cards through our Web site at www.ssspr.com.

Where You Obtain Covered Care

You obtain care from "plan providers". You will only pay coinsurance, and you will not have to file claims, except when receiving services from orthodontists, who are not "plan providers".

Plan Providers

We list plan providers in the provider directory, which we update periodically. The list is on our Web site at: www.ssspr.com or you may call us at (787)-774-6060, TTY number (787) 792-1370.

In-Network

The primary care dentists are duly authorized plan dentists with a regular license issued by the designated entity of the government of Puerto Rico, and who are bona fide members of the "Colegio de Cirujanos de Puerto Rico", who have signed a contract with Triple-S to render dental services.

Out-of-Network

We will only reimburse out-of-network services when rendered by orthodontists. No other services rendered by out-of-network providers are covered including emergency services performed by an out-of-network dentist. If you receive dental services from other out-of-network providers, you will have to pay 100% of the charges and we will not reimburse you.

Emergency services performed by an out-of-network dentist are not covered. You will have to pay 100% of the charges and we will not reimburse you.

Pre-Authorization/Pre-Determination of Benefits

Some of the objectives of the pre-determination of benefits are to evaluate if the service is necessary and verify the eligibility of the enrollee for the requested service. Pre-determinations will be evaluated based on the pre-determination policies that Triple-S has established. We will not be liable for payment of services, if they have been rendered or received without this pre-authorization/pre-determination.

The following dental benefits will require a pre-authorization/pre-determination of benefits: all crowns, fixed and removable prostheses, periodontal procedures and endodontic retreatments.

The dentist is responsible for the pre-determination of benefits and will list all services on the ADA claim form and include radiographs and a treatment plan. The dentists will submit the form by paper or electronically. For questions regarding this process, call us at 787-774-6060, TTY number 787-792-1370.

Coordination of Benefits

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

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

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

Service Area

To enroll in this plan, you must live in our service area. This is where our providers practice. Our service area is ***only*** Puerto Rico.

You must get your care from providers within the service area who contract with us. If you receive care outside our service area, you will have to pay 100% of the charges. We will not pay for services out of our service area.

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

Dental Review

Only individual crowns, removable and fixed prostheses and endodontic retreatments require dental review. Requests will be processed faster if they are accompanied with periapical radiographs with diagnostic value and brief by reports with additional clinical information that may not be evident in the radiographs.

Section 4 Your Cost For Covered Services

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

Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our plan, you pay 30% of our allowance for oral surgery.
Lifetime Benefit Maximum	In our plan, the established lifetime benefit maximum of $1,500 applies only to orthodontic services.
In-Network Services	You pay the established coinsurance for each service. Please see Section 5, Dental Services and Supplies, for more information.
Out-of-Network Services	There is no benefit payable for out-of-network services other than for orthodontia. You pay 100% of the billed charges. We will not reimburse you. Orthodontic services are reimbursed at 50% of Triple-S' established fees, up to the maximum lifetime benefit of $1,500.
Emergency Services	You pay the established coinsurance for each in-network service. For emergency services received from out-of-network providers in or outside of our service area (Puerto Rico), you pay 100% of the costs.
International Services	There is no coverage for services rendered overseas. You pay 100% of the cost.

Section 5 Dental Services and Supplies
Class A Basic

Important things you should keep in mind about these benefits:

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

You Pay:

High Option

- **In-Network:** Nothing
- **Out-of-Network:** 100% of billed charges

Diagnostic and Treatment Services

D0120 Periodic oral evaluation - *Limited to twice every 12 months, with an interval of 6 months*

D0140 Limited oral evaluation - problem focused - *Limited to twice every 12 months, with an interval of 6 months*

D0150 Comprehensive oral evaluation – *Limited to twice every 12 months, with an interval of 6 months*

D0180 **(P)** Comprehensive periodontal - *Limited to twice every 12 months, with an interval of 6 months*

D0210 Intraoral - complete series (including bitewings)

D0220 Intraoral - periapical first film

D0230 Intraoral - periapical - each additional film

D0240 Intraoral - occlusal film

D0270 Bitewing - single film

D0272 Bitewings - two films

D0274 Bitewings - four films

D0277 Vertical bitewings – 7 to 8 films

D0330 Panoramic film

D0340 Cephalometric film

D0999 Unspecified diagnostic procedure, *by report*

(P) = Services will be paid only to periodontists

Preventative Services

D1110 Prophylaxis – adult - *Limited to twice every 12 months, with an interval of 6 months*

D1120 Prophylaxis – child - *Limited to twice every 12 months, with an interval of 6 months*

D1203 Topical application of fluoride (excluding prophylaxis) – child - *Limited to twice every 12 months, with an interval of 6 months*

D1204 Topical application of fluoride (excluding prophylaxis) – adult - *Limited to twice every 12 months, with an interval of 6 months by report, for patients with special conditions; see Section 6, General Exclusions, for more information*

D1351 Sealant - per tooth - *Limited to permanent molars and premolars through age 14; one sealant per tooth for life*

Not covered:

- *Plaque control programs*
- *Oral hygiene instruction*
- *Dietary instructions*
- *Over-the-counter dental products, such as teeth whiteners, toothpaste, dental floss*
- *Services rendered by out-of-network providers*

Class B Intermediate

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- All fixed and removable prosthesis, periodontal procedures and endodontic retreatments will be subject to our pre-determination.

You Pay:

High Option

- **In-Network:** 30% of coinsurance, except for D2999, for which you will pay no coinsurance
- **Out-of-Network:** 100% of billed charges

Minor Restorative Services

D2140 Amalgam - one surface, primary or permanent

D2150 Amalgam - two surfaces, primary or permanent

D2160 Amalgam - three surfaces, primary or permanent

D2161 Amalgam - four or more surfaces, primary or permanent

D2330 Resin–based composite - one surface, anterior

D2331 Resin-based composite - two surfaces, anterior

D2332 Resin-based composite - three surfaces, anterior

D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)

D2391 Resin-based composite – one surface, posterior

D2392 Resin-based composite – two surfaces, posterior

D2393 Resin-based composite – three surfaces, posterior

D2394 Resin-based composite – four or more surfaces, posterior

D2799 Provisional crown

D2910 Recement inlay – onlay, or partial coverage restoration - *Limited to one patient, per tooth, per lifetime*

D2915 Recement cast or prefabricated post and core – *Limited to one per patient, per tooth, per lifetime*

D2920 Recement crown - *Limited to one per patient, per tooth, per lifetime*

D2930 Prefabricated stainless steel crown - primary tooth - *Limited to one per patient, per tooth, per lifetime*

D2940 Sedative filling

D2951 Pin retention - per tooth, in addition to restoration

D2999 Unspecified restorative procedure, *by report*

Not Covered:

- *Restorations, including veneers, which are placed for cosmetic purposes only*
- *Gold foil restorations*
- *Services rendered by out-of-network providers*

Endodontic Services
D3110 Pulp cap – direct (excluding final restoration)
D3120 Pulp cap – indirect (excluding final restoration)
D3220 Therapeutic pulpotomy (excluding final restoration)
D3221 Pulpal debridement, primary and permanent teeth
Periodontal Services
D4341 Periodontal scaling and root planning - four or more teeth per quadrant
D4342 Periodontal scaling and root planning - one to three teeth per quadrant
D4910 Periodontal maintenance
Prosthodontic Services
D5410 Adjust complete denture - maxillary
D5411 Adjust complete denture - mandibular
D5421 Adjust partial denture - maxillary
D5422 Adjust partial denture - mandibular
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth - complete denture (each tooth)
D5610 Repair partial denture base
D5630 Repair or replace broken clasp
D5640 Replace broken teeth - per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5710 Rebase complete maxillary denture
D5711 Rebase complete mandibular denture
D5720 Rebase maxillary partial denture
D5721 Rebase mandibular partial denture
D5730 Reline complete maxillary denture (chairside)
D5731 Reline complete mandibular denture (chairside)
D5740 Reline maxillary partial denture (chairside)
D5741 Reline mandibular partial denture (chairside)
D5750 Reline complete maxillary denture (laboratory)
D5751 Reline complete mandibular denture (laboratory)
D5760 Reline maxillary partial denture (laboratory)
D5761 Reline mandibular partial denture (laboratory)
D5899 Unspecified removal prosthodontic procedure, *by report*
D6930 Recement fixed partial denture
D6980 Fixed partial denture repair, *by report*
Oral Surgery
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220 Removal of impacted tooth - soft tissue
D7230 Removal of impacted tooth - partially bony
D7240 Removal of impacted tooth - completely bony
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7280 Surgical access of an unerupted tooth

Oral Surgery - continued on next page

Oral Surgery (cont.)
D7283 Placement of device to facilitate eruption of impacted tooth
D7286 Biopsy of oral tissue - soft
D7510 Incision and drainage of abscess - intraoral soft tissue
D7971 Excision of pericoronal gingiva
D7999 Unspecified surgical procedure, *by report*

Class C Major

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- All crowns and endodontic retreatments will be subject to our determination.

You Pay:

High Option

- **In-Network**: 60% of coinsurance, except for endodontic services and codes D2950, D2952, D2954 and D2980, for which you will pay 30% of coinsurance
- **Out-of-Network:** 100% of billed charges

Major Restorative Services

D2720 Crown – resin with high noble metal

D2722 Crown – resin with noble metal

D2750 Crown - porcelain fused to high noble metal

D2752 Crown - porcelain fused to noble metal

D2780 Crown - 3/4 cast high noble metal

D2781 Crown - 3/4 cast predominately base metal

D2782 Crown – ¾ cast noble metal

D2783 Crown - 3/4 porcelain/ceramic

D2790 Crown - full cast high noble metal

D2791 Crown - full cast predominately base metal

D2792 Crown - full cast noble metal

D2794 Crown - titanium

D2950 Core buildup, including any pins

D2952 Cast post and core in addition to crown

D2954 Prefabricated post and core in addition to crown

D2980 Crown repair, *by report*

Not covered:

- *Gold foil restorations*
- *Restorations for cosmetic purposes only*
- *Composite resin inlays*
- *Services rendered by out-of-network providers*

Endodontic Services

D3310 Endo - anterior root canal (excluding final restoration)

D3320 Endo - bicuspid (excluding final restoration)

D3330 Endo - molar (excluding final restoration)

D3346 Retreatment of previous root canal therapy-anterior

D3347 Retreatment of previous root canal therapy-bicuspid

D3348 Retreatment of previous root canal therapy-molar

D3999 Unspecified endodontic procedure, *by report*

Major Prosthodontic Services
D5110 Complete denture - maxillary
D5120 Complete denture - mandibular
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D6210 Pontic - cast high noble metal
D6212 Pontic - cast noble metal
D6240 Pontic - porcelain fused to high noble metal
D6241 Pontic - porcelain fused to predominately base metal
D6242 Pontic - porcelain fused to noble metal
D6245 Pontic - porcelain/ceramic
D6250 Pontic – resin with high noble metal
D6251 Pontic – resin with predominately base metal
D6252 Pontic – resin with noble metal
D6253 Provisional pontic
D6545 Retainer – cast metal for resin bonded fixed prosthesis
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6600 Inlay – porcelain/ceramic, two surfaces
D6601 Inlay – porcelain/ceramic, three or more surfaces
D6602 Inlay – cast high noble metal, two surfaces
D6603 Inlay – cast high noble metal, three or more surfaces
D6604 Inlay – cast predominately base metal, two surfaces
D6605 Inlay – cast predominately base metal, three or more surfaces
D6606 Inlay – cast noble metal, two surfaces
D6607 Inlay – cast noble metal, three or more surfaces
D6608 Onlay – porcelain/ceramic, two surfaces
D6609 Onlay – porcelain/ceramic, three or more surfaces
D6610 Onlay – cast high noble metal, two surfaces
D6611 Onlay – cast high noble metal, two surfaces
D6612 Onlay – cast predominately base metal, two surfaces
D6613 Onlay – cast predominately base metal, three or more surfaces
D6614 Onlay – cast noble metal, two surfaces
D6615 Onlay – cast noble metal, three or more surfaces
D6624 Inlay - titanium
D6634 Onlay - titanium
D6710 Crown – indirect resin based composite
D6720 Crown – resin with high noble metal
D6721 Crown – resin with predominately base metal
D6722 Crown – resin
D6740 Crown - porcelain/ceramic
D6750 Crown - porcelain fused to high noble metal
D6751 Crown - porcelain fused to predominately base metal
D6752 Crown - porcelain fused to noble metal
D6780 Crown - 3/4 cast high noble metal

Major Prosthodontic Services - continued on next page

Major Prosthodontic Services (cont.)
D6781 Crown - 3/4 cast predominately base metal
D6782 Crown - 3/4 cast noble metal
D6783 Crown - 3/4 porcelain/ceramic
D6790 Crown - full cast high noble metal
D6791 Crown - full cast predominately base metal
D6792 Crown - full cast noble metal
D6794 Crown - titanium
D6920 Connector bar
D6930 Recement fixed partial denture
D6940 Stress breaker
D6950 Precision attachment
D6970 Cast post and core in addition to fixed partial denture retainer
D6972 Prefabricated post and core in addition to fixed partial denture retainer

Not covered:

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

Class D Orthodontic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- The waiting period for orthodontic services is 24 months. The person receiving services must be covered under this plan for the entire waiting period.
- The lifetime maximum for orthodontic services is $1,500.
- Orthodontists are non-plan providers; **services will be covered by reimbursement at 50% of Triple-S' established fees.**

Orthodontic Services - limited to children up to age 19

D8210 Removable appliance therapy, *limited to once per lifetime*

D8220 Fixed appliance therapy, *limited to once per lifetime*

D8660 Pre-orthodontic treatment visit; *initial examination and treatment plan (including x-rays and study models),limited to once per lifetime*

D8670 Periodic orthodontic treatment visit (as part of contract); *monthly payment – post treatment stabilization*

D8680 Orthodontic retention (removal of appliances, construction and placement of retainer (s)), *limited to each per lifetime*

D8690 Orthodontic treatment (alternate billing to a contract fee); *initial payment for insertion of appliance, limited to once per lifetime*

Not covered:

- *Orthodontic care for persons age 19 and over*
- *Repair of damaged orthodontic appliances*
- *Replacement of lost or missing appliance*
- *Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth*

General Services

Important things you should keep in mind about these benefits:

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

You Pay:

High Option

- **In-Network:** 30% of coinsurance
- **Out-of-Network:** 100% of billed charges

General services
D9420 Hospital Call
D9910 Application of desensitizing medicament
D9930 Treatment of complications (post-surgical) – unusual circumstances, by report
D9999 Unspecified adjunctive procedure, by report

Not covered:

- *Nitrous oxide*
- *Oral sedation*
- *Services rendered by out-of-network providers*

Section 6 General Exclusions – Things We Do Not Cover

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

We do not cover the following:

- Any dental service or treatment not specifically listed as a covered service;
- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Services and treatment which are experimental or investigational;
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the law or regulation of any governmental unit. This exclusion applies whether or not you claim the benefits or compensation;
- Services and treatment received from a dental 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 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 the FEHB or other medical insurance even when provided by a general dentist or oral surgeon;
- Services rendered by out-of-network providers, in or outside of Puerto Rico, except by orthodontists in Puerto Rico.
- Services needed as a result of a traffic accident;

- Fluoride treatment for adults, except for patients that have lost their salivary function, due to radiation or medications, in order to prevent and control caries.

Section 7 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

When you see plan providers, you will not have to file claims. Just present your identification card and pay your coinsurance.

You will only need to file a claim when you receive orthodontic services. You will have to submit the claim within one (1) year since the date of service. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

1. Claims for orthodontic reimbursement: In most cases, providers file claims for you. Dentists must file an ADA claim form. For claims questions and assistance, call us at 787-774-6060, TTY number 787-792-1370. When you receive orthodontic services, you must file an ADA claim form or a claim that includes the information shown below. Bills and receipts should be itemized and:

(a) Must be sent to: Triple-S, PO Box 363628, San Juan, PR 00936-3628; and

(b) Verify that the receipts have the information about the dentist printed on it and that the name of the insured agrees with the contract number. The Request for Reimbursement Form will be accepted as a receipt as long as it has the dentist information printed; the dentist's signature and his/her license number.

(c) When requesting reimbursement for the first time, the insured must include:

• the treatmentplan detailing the first visit

• down payment

• monthly payments

• total cost

• duration of treatment.

(d) Receipts must agree with what was established in your treatment plan.

(e) If the insured pays more than one visit in the same receipt, he/she must send the exact dates (month, day, and year) of the services for which he/she paid.

(f) Payments in advance or total payment of the treatment will not be considered for reimbursement.

(g) If you pay for retainers, it must be indicated if they are mandibular or maxillary.

(h) If you request reimbursement for orthodontic devices, it must be indicated if they are fixed (D8220) or removable (D8210).

To request reimbursement through Coordination of Benefits add:

• Contract number of the other plan

• If the reimbursement is for amounts left unpaid by your other plan, you must include the other plan's Explanation of Benefits.

2. We have a period of 30 days after our receipt of the claim to:

(a) Notify you of our determination.

(b) Request additional information. You will have up to 45 days to provide the requested information.

(c) Inform you that more time is needed to make a decision. This extension may consist of a maximum of 15 additional days.

Deadline for Filing Your Claim

Send us all 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:

- Write to us within the 180 days from the date of our determination.
- Include in your letter the reason why you believe that the initial determination is incorrect.
- Enclose copies of the documents that support your claim, such as a letter from the dentists, and the explanations of benefits.
- Submit your written complaint to the following address: Triple-S, Inc., Customer Service Department, Complaints and Grievances Unit, P.O. Box 363628, San Juan, PR 00936-3628.

2. We will notify you about our decision on your complaint no later than 30 days from the date your complaint was received. If we need more time to make our decision, we will notify you in writing. In said cases, the term to answer your complaint will not exceed a period of 15 days.

3. If the dispute is not resolved through the reconsideration process, you may request a review of the denial. You may request a reconsideration within 60 days from the date you received the notification of our determination. You may send your reconsideration request to the same address to which you sent your complaint. In your reconsideration request, you must include the reason(s) why you understand Triple-S was mistaken in its initial determination. We must answer your request for reconsideration with a term of 30 days.

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 8 Definitions of Terms We Use in This Brochure

Annual Benefit Maximum	The maximum annual benefit that you can receive per person.
Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Class A Services	Basic services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
Class B Services	Intermediate services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, oral surgery and denture adjustments.
Class C Services	Major services, which include endodontic services such as root canals, periodontal services such as scaling and root planing, major restorative services such as crowns, bridges and prosthodontic services such as complete dentures.
Class D Services	Orthodontic services.
Enrollee	The Federal employee or annuitant enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Generally Accepted Dental Protocols	Clinically adequate procedures accepted by the different academies of the dental profession.
Plan Allowance	The amount we allow for specific procedures.
Waiting period	The amount of time that you must be enrolled in this plan before you can receive orthodontic services.
We/Us	Triple-S
You	Enrollee or eligible family member.

Stop Health Care Fraud!

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, plan, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your explanation of benefits (EOBs) statements.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 787-774-6060, TTY number 787-792-1370 and explain the situation.
- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self- support).

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

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

You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the plan.

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Summary of Benefits

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

High Option Benefits	**You Pay** **In-network**	**You Pay** **Out of network**	**Page**
Class A (Basic) Services – preventative and diagnostic	Nothing		11
Class B (Intermediate) Services – includes minor restorative, endodontic, periodontal, prosthodontic and oral surgery services	30%, except for D2999, for which there is no coinsurance	100%	12
Class C (Major) Services – includes major restorative, endodontic, and major prosthodontic services	60%, except for some major restorative services, and for endodontic services, for which is 30%	100%	15
Class D Services – orthodontic services $1,500 Lifetime Maximum	Covered by reimbursement at 50% of Triple-S' established fees		18
General Services	30%	100%	19

Rate Information

Monthly and Bi-weekly Rates

Monthly High Option Self Only	Monthly High Option Self Plus One	Monthly High Option Self and Family	Bi-weekly High Option Self Only	Bi-weekly High Option Self Plus One	Bi-weekly High Option Self and Family
$9.77	**$19.54**	**$25.85**	**$4.51**	**$9.02**	**$11.93**