SECTION 20: FEDERAL EMPLOYEE PROGRAM (FEP) – BASIC AND STANDARD OPTIONS

A. Overview

The Federal Employee Program (FEP) is a nationwide Federal Employees program administered through the local Blue Cross and Blue Shield Association. ***This program should NOT be confused with HMSA's Plan for Federal Employees.*** The FEP membership card is identified by coverage codes 104, 105 and 106 for the Standard Option and 111, 112 and 113 for the Basic Option.

As of January 2014, dentists who participate in the HMSA Dental network, may provide care to members of both the FEP Basic Option and Standard Option plans. You can determine which plan a member has by looking at the ID card. (See samples on the following pages.) The card will have a unique ID number beginning with an "R" to indicate FEP, as well as one of these enrollment codes.

As of January 2014, members may receive their dental services from any of our HMSA participating dentists and receive their covered services at the HMSA Maximum Allowable Charge.

HMSA is responsible for servicing the Participating Dentist Network for FEP, and for ensuring the accuracy of the online provider directory and the provider file used for claims processing.

For services performed by participating dentists and specialists in our HMSA Dental Provider Network, the member will owe the difference between the benefit amount and the HMSA Maximum Allowable Charge (MAC).

Providers should always verify member eligibility via HHIN Blue Exchange Eligibility or by calling HMSA Dental Customer Service at **808-948-6281** on Oahu or **808-966-6198 toll-free** on the Neighbor Islands.

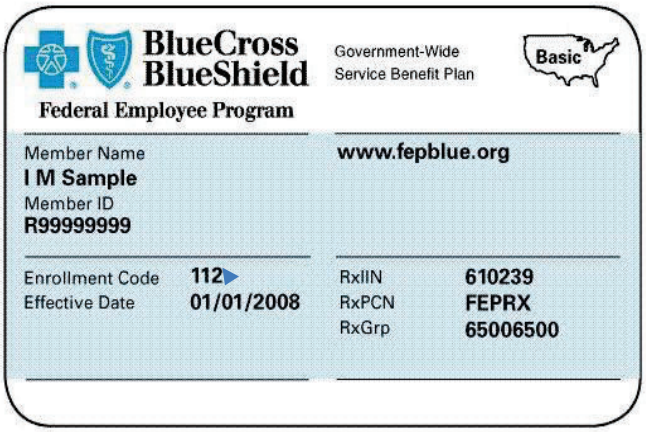
For current FEP plan benefit details, brochures, and guidelines, please refer to the fepblue.org website. For your convenience, we have included the applicable year's benefit details within this section on the following pages.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

B. Highlights of Basic and Standard Options

Features of Basic and Standard Options
• The Basic and Standard Options have separate lists of covered services. • For procedures on both lists, the MAC is the same. • For procedures not covered under either option, you may charge your usual and customary fee. • If a procedure is not covered under FEP, do not bill it to FEP (unless you require a rejection for coordination of benefits). • Neither plan requires payment of a deductible. • The Customer Service for both options are: Oahu (808) 948-6281 and for the Neighbor Islands (800) 966-6198 Toll Free • Complete benefit information and limitations are outlined in the FEP Service Benefit Plan Brochure, located on the fepblue.org website, (Pages 126-129). For your convenience, we have included 2022 dental benefit details within this section of this HMSA dental manual.

C. FEP Basic Option – Sample Member ID Card



Basic Option identified by a 111, 112 or 113

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

D. FEP Basic Option – Benefits and Limitations

Benefits

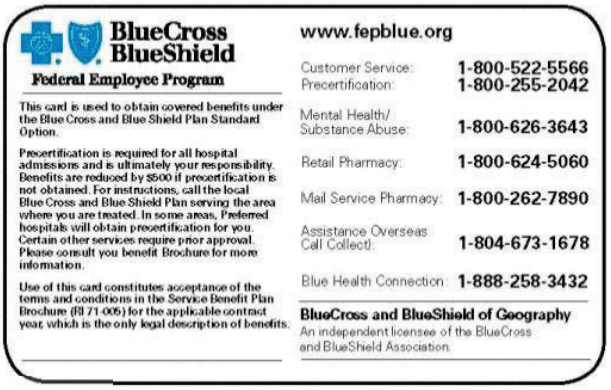
- **Benefits are available only when a participating dentist renders treatment.**
- **Coverage is limited to basic and preventive services. Covered codes are listed in detail on the FEP schedule, located at www.fepblue.com**
- **A fixed copayment of $30 is applicable when a covered evaluation is billed (D0120, D0140, D0150). The $30 copayment is payable by the member at the time of service.**
- **There is a fixed MAC for each covered procedure.**
- **FEP pays MAC for each covered procedure less any applicable $30 copayment.**
- **Members may not be billed more than the $30 copayment for covered services.**
- **Sealants are covered.**

Limitations

- **Clinical Oral Evaluations (ADA codes: D0120, D0150): Benefit limited to a combined total or two evaluations per person, per calendar year.**
- **Radiographs:**
  - **Intraoral complete series, including bitewings (D0210): Benefit limited to one complete series every three (3) years.**
- **Preventive:**
  - **Prophylaxis (ADA codes D1110, D1120): Prophylaxis benefits limited to two (2) per calendar year.**
  - **Fluoride (ADA codes D1206, D1208). Fluoride benefits limited to children only, two per calendar year**
  - **Sealants: (D1351) Benefit is available for covered children up to age sixteen (16) at a limit of one (1) per tooth for the first and second molars only.**
- **Complete benefit information and limitations are outlined in the FEP Service Benefit Plan Brochure, located on the fepblue.org website, (Pages 126-129). For your convenience, we have included the applicable year's dental benefit details within this section of this HMSA dental manual.**

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

E. FEP Standard Option – Sample Member ID Card



Standard Option identified by a 104, 105 or 106

Standard Option Features
Benefits • There is a fixed MAC for each covered procedure. • There is a fixed copayment (a portion of MAC) for each covered procedure dependent upon the patient's age. Copayments are payable by the member at the time of service. • Sealants are not covered. You may bill Standard Option members at your usual and customary charge for this procedure.
Limitations • Clinical Oral Evaluations (ADA Code: D0120): Benefit is limited to two evaluations per person, per calendar year. • Prophylaxis (ADA Codes: D1110, D1120): Benefit is limited to two per person, per calendar year. • Fluoride (ADA Codes: D1206, D1208): Benefit is limited to two per person, per calendar year

Listed below are the 2025 benefits.

Plan Option	Self Only	Self + 1	Self + Family
Standard Option	104	106	105
Basic Option	111	113	112

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

F. FEP Standard Option (Medical Plan) Benefit Table

Dental Benefit Covered Service	We Pay		You Pay
Clinical Oral Evaluations	To Age 13	Age 13 & Over	All charges more than the scheduled amounts listed to the left. NOTE: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Periodic oral evaluations *(Up to 2 per person per calendar year)*	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive Oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
Diagnostic Imaging	To Age 13	Age 13 & over	
Intraoral complete series	$36	$22	
Palliative Treatment	To Age 13	Age 13 & over	All Charges
Palliative treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive	To Age 13	Age 13 & over	
Prophylaxis – adult (*Up to 2 per person per calendar year)*	--	$16	
Prophylaxis – child (*Up to 2 per person per calendar year)*	$22	$14	
Topical application of fluoride or fluoride varnish (*Up to 2 per person per calendar year)*	$13	$8	
Not covered: Any service not specifically listed above	Nothing	Nothing	

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

G. FEP Basic Option (Medical Plan) Benefit Table

Dental Benefit Covered Services	We Pay	You Pay
Clinical Oral Evaluations	Preferred: All charges more than your $30 copayment Participating/ Non-participating: Nothing	Preferred: $30 copayment per evaluation Participating/Non-participating: You pay all charges
Periodic oral evaluation*		
Limited oral evaluation		
Comprehensive oral evaluation*		
***Benefits are limited to a combined total of 2 evaluations per person per calendar year**		
Diagnostic Imaging		
Intraoral – complete series including bitewings *(limited to 1 complete series every 3 years)*		
Preventive		
Prophylaxis – adult *(up to 2 per calendar year)*		
Prophylaxis – child (*up to 2 per calendar year)*		
Topical application of fluoride or fluoride varnish – for children only *(up to 2 per calendar year)*		
Sealant – per tooth, first and second molars only *(once per tooth for children up to age 16 only)*		
Not covered: Any service not specially listed above	Nothing	All charges

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

H. Accidental Injury Benefit – Fed 27 and Fed 34

Accidental injury benefit	You Pay	
	Standard Option	**Basic Option**
We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required because of, and directly related to, an accidental injury. To determine benefit coverage, we may require documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses. **Note:** An **accidental injury** is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries. **Note:** A **sound natural tooth** is a tooth that is whole or properly restored (restoration with amalgams or resin-based composite fillings only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount. **Note:** Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.	$30 copayment per visit **Note: We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers.** See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. **Note:** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

I. Coordination of Benefits (FEP)

As explained in Section 14, coordination of benefits (COB) involves two or more payors plan identified as working together to share the cost of healthcare expenses, with one primary (this plan pays first) and the other plan as secondary (this plan pays second). COB allows payors to help manage the cost of healthcare by avoiding payment of more than the total reasonable expenses incurred.

When FEP is the secondary payor, we will adhere to these guidelines.
We will pay the difference between the primary Payor's payment and the lower of the MAC allowance or the dentist's charge.

If the primary Payor's payment is equal to or greater than the Allowable Charge (MAC) allowance, FEP will not owe a Maximum payment.
If the primary Payor's payment is less than our allowance, we will coordinate and process up to the fee schedule not to exceed the MAC.

J. How to File a Claim (FEP)

When filing claims for FEP Basic and Standard plan members, please do the following:

1. Include the policy subscriber's ID number—an R followed by eight digits—in block 15 of the ADA claim form.
2. Make sure the provider has signed the claim form.
3. FEP Dental claims should be mailed to the following address to ensure timely processing:

   HI FEP Claims
   P.O. Box 69401
   Harrisburg, PA 17106-9436

4. FEP's late claim/timely filing limitation is defined as December 31st of the year following the date of service. (E.g., for a service rendered on April 1, 2024, the timely filing deadline would be December 31, 2025). This filing limitation is outlined in the FEP Service Benefit Plan Brochure, located on the fepblue.org website.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

K. Reconsideration of an FEP claim

FEP Dental Claims are paid by your local Blue Cross Blue Shield Plan (hereinafter referred to as the Local Plan). Within six (6) months of the initial claim decision, you may ask the Local Plan in writing to reconsider the claim decision. Follow Step 1 of the disputed claims process below.

Step 1: To request reconsideration of a claim decision you must:

- Write to the Local Plan within six (6) months from the date of the decision; and
- Send your request to the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim; and
- Include a statement about why you believe the initial decision was wrong, based on specific benefit provisions; and
- Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, dental records, and explanation of benefits (EOB) forms.

The Local Plan will provide you, in a timely manner, with any new or additional evidence considered, relied upon, or generated at its direction in connection with the claim and any new rationale for the claim decision. The Local Plan will provide you with this information sufficiently in advance of the date that it is required of the reconsideration decision to allow you a reasonable opportunity to respond before that date. However, the Local Plan's failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate its decision on reconsideration. You may respond to that new evidence or rationale at the Office of Personnel Management (OPM) review stage described in Step 3.

Step 2: In the case of a post-service claim, the Local Plan has thirty (30) days from the date it receives your request to:

- Pay the claim or
- Write to you and maintain its denial or
- Ask you or your patient for more information.

You or your patient must send the information so that we receive it within 60 days of our request. The Local Plan will then decide within 30 more days. If the Local Plan does not receive the information within 60 days, a decision will be made within 30 days of the date the information was due. The decision will be based upon the information already on file. The Local Plan will provide a written response regarding its decision.

Step 3: If you do not agree with the decision, you may ask OPM to review it. You must write to OPM within:

- 90 days after the date of the Local Plan's letter upholding the initial decision; or
- 120 days after you first wrote to OPM – if they did not answer that request in some way within 30 days: or
- 120 days after OPM asked for additional information – if OPM did not send you a decision within 30 days after receiving the additional information.

Write to OPM at:

United States Office of Personnel Management
Federal Employee Insurance Operations, Health Insurance
1900 E Street, NW Washington, DC 20415-3610

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.