TRICARE®
Dental Program Benefit Booklet

For active duty family members and National Guard and Reserve members and their families
TRICARE Dental Program (TDP) Contact Information and Resources

United Concordia Online:
- Find a dentist
- Check on a claim
- View plan design details
- TDP benefit materials (e.g., booklet, forms)

Beneficiary Web Enrollment Portal:
- Enrollment
- Termination of enrollment
- Add/remove beneficiary
- View premium rates
- Request TDP identification card

United Concordia By Phone:
- General inquiries
- Claims
- Billing assistance
- Enrollment
- Termination of enrollment
- Add/remove beneficiary
- Request TDP benefit materials

* United Concordia representatives can be reached by phone 24 hours a day from Sunday at 6 p.m. (ET) through Friday at 10 p.m. (ET), except holidays. Customer service representatives are available to assist beneficiaries in the following languages: English, German, Italian, Japanese, Korean and Spanish.

An Important Note about TRICARE Dental Program Information
This TRICARE Dental Program Benefit Booklet will help you learn about your TDP benefits and services. At the time of printing, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. For the most recent information, contact United Concordia at 1-844-653-4061 (CONUS), 1-844-653-4060 (OCONUS toll-free), 1-717-888-7400 (OCONUS toll) or visit them online at www.uccitdp.com. More information regarding TRICARE, including the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices, can be found online at www.tricare.mil.
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See the inside back cover of this booklet for “TRICARE Expectations for Beneficiaries.”
The TRICARE Dental Program (TDP) is a worldwide dental care program offered to eligible beneficiaries by the Department of Defense through the Defense Health Agency. The TDP makes it cost effective and convenient to care for your oral health.

United Concordia Companies, Inc. (United Concordia), the TDP contractor, is committed to beneficiary-centered administration of the TDP to help you and your loved ones enjoy good oral health. Please refer to the contact information on the inside front cover any time you need assistance.

The TDP is divided into two geographical service areas: continental United States (CONUS) and outside the continental United States (OCONUS). The TDP CONUS service area includes the 50 United States, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. The TDP OCONUS service area includes areas not in the CONUS service area and covered services provided on a ship or vessel outside the territorial waters of the CONUS service area.
Eligibility and Enrollment

Eligible beneficiaries include family members and legal dependents of members of the seven uniformed services, National Guard and Reserve members, and/or National Guard and Reserve family members. The uniformed services include the: U.S. Air Force, U.S. Army, U.S. Navy, U.S. Marine Corps, U.S. Coast Guard, Commissioned Corps of the National Oceanic and Atmospheric Administration, and the U.S. Public Health Service.

TRICARE Dental Program (TDP) eligibility is confirmed using the Defense Enrollment Eligibility Reporting System (DEERS). Make sure all DEERS records are current to avoid unnecessary processing delays!

Individuals Eligible to Enroll in the TDP

Active duty family members (ADFM) and National Guard and Reserve family members:

• Spouses
• Unmarried children until age 21 (including stepchildren, adopted children—both pre-adoptive and finalized adoption—, and court-ordered wards). These children are eligible up to the end of the month in which they turn 21.
• Unmarried children between ages 21 and 23:
  • Up to age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50 percent of the financial support. These students are eligible up to the end of the month in which they turn 23 or graduate.
  • They have a disabling illness or injury that occurred before their 21st birthday; or they have a disabling illness or injury that occurred between ages 21 and 23 and, at the time of the illness or injury, were enrolled in a full-time course of study at an approved institution of higher learning, and the sponsor provided over 50 percent of the financial support.

National Guard and Reserve service members:

• Members of the Individual Ready Reserve (IRR) and the Selected Reserve of the Ready Reserve may enroll in the TDP when they are not on active duty orders for a period of more than 30 consecutive days. Any National Guard or Reserve member who is called or ordered to active duty for a period of more than 30 consecutive days receives the same benefits as an active duty service member (ADSM) and are not eligible to enroll in the TDP.

Verifying and Updating Eligibility

The TDP contractor verifies beneficiary eligibility through DEERS. It is extremely important that DEERS contains up-to-date information on each family member. If the information in DEERS does not match the information you provide during the enrollment process, enrollment in the TDP may be denied or delayed. Only the sponsor can add or delete family members within DEERS or the Beneficiary Web Enrollment (BWE) website. Sponsors or registered family members may make address and contact information changes. (The BWE portal is accessible at www.tricare.mil/bwe). The addition or deletion of family members requires proper documentation such as a marriage certificate and/or birth certificate in person at a uniformed services ID office or a copy of a notarized DEERS form that is provided to the DEERS office. You can update DEERS contact information in one of the following ways:

1. Online at http://milconnect.dmdc.osd.mil or www.dmdc.osd.mil/rsl. This method is a quick and easy way to update address and contact information.
2. In Person by visiting a local personnel office that has a uniformed services identification (ID) card-issuing facility. To locate the nearest facility, visit www.dmdc.osd.mil/rsl. Please call ahead for hours of operation and for detailed instructions.
3. Call the Defense Manpower Data Center Support Office at 1-800-538-9552. Hours of operation are Monday—Friday, 5:00 a.m.—5:00 p.m. (PT), except on federal holidays.
4. Fax changes to DEERS at 1-831-655-8317. The sponsor’s Department of Defense Benefits Number and/or Social Security number must be included with the faxed documents.
5. **Mail** changes to:
   
   Defense Manpower Data Center  
   Support Office  
   Attn: COA  
   400 Gigling Road  
   Seaside, CA 93955-6771

**Individuals Who Are Not Eligible for TDP Coverage**

The following are **not** eligible to enroll in the TDP:

- ADSMs, including National Guard and Reserve members called to active duty for more than 30 consecutive days
- Retired service members and their families
- Former spouses
- Parents and parents-in-law
- Disabled veterans
- Foreign military personnel
- Service members in the Transitional Assistance Management Program (TAMP) following activation for 30 days in support of a contingency operation

**Enrollment Options**

- Enrollment in the TDP can be obtained through a single or family plan.
- National Guard and Reserve sponsors are only eligible to enroll under a single plan.
- National Guard and Reserve family members can enroll under a separate single or family plan.

**Single Plan**

A single enrollment is defined as one eligible beneficiary and may include:

- One active duty family member (ADFM)
- One National Guard or Reserve family member
- One National Guard or Reserve sponsor

If the National Guard or Reserve sponsor chooses to enroll along with a family member(s), there will be separate premium bills—one for the sponsor’s single plan and one for the family member’s single or family plan.

**Family Plan**

A family enrollment is defined as two or more covered family members. A National Guard or Reserve sponsor cannot be included in the family plan. As such, if a sponsor chooses to enroll, it will be a separate single enrollment.

Under the TDP family enrollment, if one family member is enrolled, all eligible family members must be enrolled, except in the following situations:

- Children under age 1 may be voluntarily enrolled at any time. However, these children can be excluded from enrollment at the discretion of the sponsor if there is only one enrolled beneficiary in the family age 1 or older. Current dental care research has demonstrated improved long term oral health for children when dental care is started as young as one year of age.
- If a sponsor has family members living in two or more locations (for example, in the case of children who are attending college away from home or living with a custodial parent/former spouse), they may choose to enroll the family members living in one location or may elect to enroll eligible family members residing in multiple locations. The sponsor must identify those family members residing in separate locations and report the information to the TDP contractor.
- For ADFM dental care that requires a hospital or special treatment environment (due to a medical condition, physical handicap, or behavioral health condition), the family member may not be allowed to enroll in the TDP and may continue to receive care from a military treatment facility (MTF). However, the sponsor must provide TDP with documentation, such as a signed letter or memorandum from the provider or administrator, confirming that this requirement is met. Before getting the services, the sponsor must also provide documentation with any request to end enrollment.

- National Guard and Reserve sponsors must enroll independently of their family members. National Guard and Reserve sponsors can enroll their family members and not themselves. If sponsors choose to enroll themselves in addition to the family member(s), there will be separate premium bills for each plan—one for the sponsor and one for the family member(s).

**Note:** Beneficiaries cannot be enrolled under two TDP contracts. Two sponsors cannot enroll the same family member(s). Additionally, if both spouses are ADSMs, both sponsors cannot enroll each other as a family member. If one is a National Guard or Reserve sponsor, the other must enroll independently.
Reserve sponsor (not activated for more than 30 consecutive days), he or she can be enrolled as a family member under the other sponsor.

**Automatic Enrollment of Children at Age 1**

If there is an existing family plan in effect, children will be automatically enrolled on the first day before they are age 1. If the existing plan is for a single family member only, the premium will change from the single plan rate to the family plan rate.

Please remember dental care is not covered by the TDP until the coverage effective date noted on the TDP ID card. Note that an ID will be provided to your milConnect account upon TDP enrollment at [www.dmdc.osd.mil/milconnect](http://www.dmdc.osd.mil/milconnect). After logging in, you can retrieve your TDP ID card by selecting “View My Healthcare Coverage” then clicking the “Dental Coverage” tab. Your ID card is located in the “Related Links” section on this tab.

If you have deleted your ID card in your milConnect account, you can request a new one be sent to your milConnect account through the BWE portal at [www.tricare.mil/bwe](http://www.tricare.mil/bwe).

**Enrollment Period**

All beneficiaries must remain enrolled in the TDP for at least 12 months, unless the termination of enrollment request qualifies as an exception (See Figure 2.1). After completing the 12-month minimum-enrollment period, enrollment may be continued on a month-to-month basis until an enrollment termination request is made by the sponsor.

Enrollees with unpaid premiums will be locked out for 12 months before they can request reenrollment.

**Enrolling in the TDP**

There are three convenient ways to enroll in the TDP. Please reference the inside front cover of this booklet for contact information and details.

- **Online**
  - **Step one:** Go to [www.tricare.mil/bwe](http://www.tricare.mil/bwe) to access the BWE portal
  - **Step two:** Click on the red “Log On” link at the top of the page
  - **Note:** You must have a Common Access Card, DFAS (myPay) Account or a DoD Self-Service (DS Logon) Premium (Level 2) account to log in.
  - **Step three:** Select the “Dental” tab to enroll in a dental plan

- **Telephone**
  - CONUS: 1-844-653-4061
  - OCONUS: 1-844-653-4060 (toll-free) 1-717-888-7400 (toll)
  - TDD/TTY service for the hearing impaired: 711

- **Mail**
  - Mail the completed *TDP Enrollment Authorization* document along with the initial premium payment (check, money order, or credit card) to the TDP contractor at:
    - United Concordia
    - TRICARE Dental Program
    - P.O. Box 645547
    - Pittsburgh, PA 15264

**Premium Payment**

- **Initial payment**—For the first month of coverage, your initial payment can be made by credit card for enrollments completed online, by phone, or by mail. You have the option of paying by check or money order for enrollments
done by mail. However, most members will find online enrollment to be the fastest and most convenient method.

- **Ongoing payments**—Payroll allotment is the required method for ongoing payment for enrollments associated with an ADSM. However, ongoing payments for enrollments associated with a National Guard or Reserve sponsor can be made with a credit card, electronic funds transfer, or payroll allotment.

**Note:** Most beneficiaries will find enrolling online to be the fastest and most convenient method. However, if enrolling by mail, the sponsor must complete the TDP Enrollment Authorization document and forward it to the TDP contractor for processing. If the sponsor is not available to complete and sign the document, an individual with a power of attorney (POA) can initiate enrollment, provided the POA allows the individual to enter into contracts. Please be sure to provide a copy of the valid POA when enrolling. Please reference the front inside cover of this booklet for TDP contractor contact information if you have any questions regarding POA.

If any information is missing or the information provided does not match the information in DEERS, the enrollment/change may be rejected and the initial premium payment will be refunded. The sponsor will then be responsible for completing a new TDP enrollment and initial premium payment. The enrollment/change will then be processed for the next available effective date.

Enrollment for TDP coverage will be confirmed with the issuance of TDP ID cards. Please remember the TDP does not cover dental care until the enrollment effective date noted on the card.

TDP benefits are available worldwide and move with you when transferring to or from the CONUS or OCONUS service area.

Current federal statute and regulations prohibit enrolled family members from receiving TDP covered services in military dental treatment facilities (DTFs) in CONUS locations. Exceptions are emergency treatment, certain pediatric specialty cases, and dental care incidental to medical care delivered in an MTF. In OCONUS locations, access to care in a DTF is based on the operational requirements and the resources of that particular facility. TRICARE encourages you to contact your DTF to learn what dental care they can provide to enrolled family members, so you can make an informed decision to enroll or remain enrolled in the TDP when moving to OCONUS locations.

**Effective Date of Coverage**

When the TDP contractor receives a request for enrollment, an inquiry will be made to DEERS to confirm eligibility. If eligibility is confirmed, the appropriate initial premium payment is received, and the request for enrollment contains all necessary information, the contractor will enroll you and/or your family members in the TDP. If initial payment is received by the 20th of the month, coverage will be processed for the first day of the month following the date of receipt. If the initial premium payment is received after the 20th of the month, coverage will be processed for the first day of the second month after receipt of the documents.

For example: If the initial premium payment is received on May 20, coverage will be effective June 1. If the request for enrollment and initial premium payment are received May 21, coverage will be effective July 1. Enrollment is processed according to the date received (not the postmark date). For example, if the TDP contractor processes your request between May 21 and June 20, the enrollment/termination will start on July 1.

If eligibility cannot be confirmed, you will be instructed to contact the uniformed services personnel office to resolve the issue. In this instance, the enrollment application will be rejected and coverage will not begin until the issue is resolved and eligibility can be verified. Any dental care provided prior to the enrollment effective date will not be covered by the TDP.

**Evidence of Coverage**

Enrolled beneficiaries may print-out an enrollment card from www.dmdc.osd.mil/milconnect/. This card should be presented at each dental office visit. Replacement cards can
be obtained in the same manner at any time or may be requested by accessing the BWE portal at www.tricare.mil/bwe. TRICARE highly recommends that your dentist obtain current coverage information from the TDP contractor before rendering services.

**Events Affecting Your Enrollment**

There are a variety of reasons for adding a family member to the TDP such as:
- Marriage
- Birth
- Adoption (pre-adoptive and finalized adoption as reflected in DEERS)
- Stepchild or court-ordered ward newly eligible for TDP
- Child turning age 1

There are also reasons for loss of eligibility or for deleting a family member from the TDP such as:
- Death
- Divorce—there is no former spouse coverage for this program
- Loss of child’s eligibility when he or she marries or turns 21 or 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50 percent of the financial support

DEERS will issue a disenrollment notice in the event of any disenrollment, regardless of reason. Loss of eligibility, if known to DEERS, as in aging out, will result in automatic disenrollment. In the case of a divorced spouse, the sponsor will have to take action to effect the disenrollment.

Termination of enrollment from the TDP is dependent upon meeting your 12-month initial enrollment period or having a valid reason to terminate enrollment. (For a list of valid reasons to terminate enrollment, see Figure 2.1).

**How to Add a Family Member, Delete a Family Member, or Terminate Enrollment from the TDP**

There are three convenient ways to add a family member, delete a family member, or terminate enrollment from the TDP: online, by telephone, or by mail. Please reference the inside front cover of this booklet for contact information and details.

**Note:** Most enrollees will find going online to be the fastest and most convenient method. When submitting by mail, the TDP Enrollment Authorization document can be downloaded from the BWE website, accessible at www.tricare.mil/bwe. Please print, complete, and mail the TDP Enrollment Authorization document to the TDP contractor.

If the sponsor is not available to complete an enrollment or terminate an enrollment, an individual with an appropriate POA can do so on their behalf. A copy of the valid POA must be on file with the contractor. To put a POA on file, please include it with your paper enrollment form, submit the appropriate form on the TDP contractor’s website, or download and mail a completed POA form and a copy of the POA to the contractor.

**Important Note Regarding the Effective Date of Enrollments and Termination of Enrollments**

For most scenarios, if the enrollment or termination of enrollment is completed by the 20th of the month, it will be effective the first day of the following month. If the enrollment/termination of enrollment is received after the 20th of the month, the cancellation will be processed on the first day of the second month.

For example, if your termination of enrollment request is received by June 20, the termination will take effect on July 1. If your termination request is received on June 21 through July 20, the termination of enrollment will take effect on August 1. If the request is made by mail, it will be processed according to the date of receipt (not postmark). Please remember, you are responsible for all monthly premiums until coverage ends.
### Acceptable Reasons to Terminate Enrollment Before Completing the Initial 12-Month Enrollment Period

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRICARE Dental Program (TDP) family member loses eligibility.</td>
<td>Sponsor or family member loses eligibility for the TDP due to death, divorce, marriage, age limit of a child, or end of eligibility. See Figure 2.3 later in this section for more information.</td>
</tr>
<tr>
<td>Sponsor and family are relocated to the OCONUS service area.</td>
<td>TDP beneficiaries may terminate enrollment within 90 calendar days of the transfer. Before terminating enrollment, please confirm that the local uniformed services dental treatment facility (DTF) can take care of the dental care needs of enrolled family members. The date of the relocation must be included on the termination of enrollment request.</td>
</tr>
<tr>
<td>Active duty service member (ADSM) receives permanent change of station orders.</td>
<td>If an ADSM transfers with TDP-enrolled family members to a duty station where space-available dental care is available at the local DTF, the ADSM may choose to terminate enrollment of his or her family members from the TDP within 90 calendar days of the transfer. The date of the transfer must be included on the termination of enrollment request.</td>
</tr>
<tr>
<td>National Guard or Reserve sponsor is deactivated.</td>
<td>Family members’ enrollment will be terminated before the end of the mandatory 12-month initial enrollment period if initially enrolled within 30 days of sponsor activation.</td>
</tr>
<tr>
<td>National Guard or Reserve member is transferred to Standby Reserve or Retired Reserve.</td>
<td>A National Guard or Reserve member will be terminated from enrollment before the end of the mandatory 12-month enrollment period if the member is transferred to the Standby Reserve or Retired Reserve.</td>
</tr>
</tbody>
</table>

### Enrollment Change/Termination of Enrollment Scenarios

If you fail to pay your TDP monthly premium(s), your TDP enrollment will be terminated. You will be prohibited from reenrolling in the program, or “locked out,” for 12 months following the last month that premiums were paid.

Figure 2.2 describes additional scenarios that would cause a change in enrollment from the TDP.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Change in TRICARE Dental Program (TDP) Enrollment</th>
</tr>
</thead>
</table>
| Two active duty service members (ADSMs) are married with TDP-enrolled children. The parent listed as the sponsor leaves active duty service. | • TDP-enrolled children’s enrollment is terminated as of 11:59 p.m. on the last day of the month in which the parent listed as the sponsor leaves active duty service. If the sponsor leaves the service on the first day of the month, the last day of coverage is the last day of the previous month.  
  • Remaining ADSM may reenroll family. The new sponsor must reenroll within 30 days of cancellation to prevent a lapse in coverage and continue the original 12-month initial enrollment period. |
| An ADSM transfers from active duty to the Selected Reserve of the Ready Reserve or Individual Ready Reserve (IRR) (special mobilization category). | • TDP-enrolled family members’ enrollment is terminated as of 11:59 p.m. on the last day of the month in which the sponsor changes status. If the sponsor changes status on the first day of the month, the last day of coverage is the last day of the previous month.  
  • Sponsor may enroll self and/or reenroll family members. The new sponsor must reenroll within 30 days of cancellation to prevent a lapse in coverage and continue the original 12-month initial enrollment period. |
### Enrollment Change/Termination of Enrollment Scenario (continued)  
**Figure 2.2**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Change in TRICARE Dental Program (TDP) Enrollment</th>
</tr>
</thead>
</table>
| A National Guard or Reserve member (*non-contingency related*) transfers to the Selected Reserve of the Ready Reserve or IRR (*special mobilization category*). | • TDP-enrolled family members’ enrollment is terminated as of 11:59 p.m. on the last day of the month in which the sponsor changes status. If the sponsor changes status on the first day of the month, the last day of coverage is the last day of the previous month.  
• Family members are automatically reenrolled in the TDP as Selected Reserve/IRR family members. Appropriate premium change will apply. |
| Sponsor transfers to another service branch.                               | • TDP-enrolled sponsor and/or family members’ enrollment is terminated as of 11:59 p.m. on the last day of the month in which the sponsor transfers to another branch. If the sponsor transfers branches on the first day of the month, the last day of coverage is the last day of the previous month.  
• Sponsor may reenroll self and/or family members. The new sponsor must reenroll within 30 days of termination to prevent a lapse in coverage and continue the original 12-month initial enrollment period. |
| A Selected Reserve of the Ready Reserve or IRR (*special mobilization category*) sponsor changes status to IRR (*other than special mobilization category*). | • TDP-enrolled sponsor and/or family members’ enrollment is terminated as of 11:59 p.m. on the last day of the month in which the sponsor changes status. If the sponsor changes status on the first day of the month, the last day of coverage is the last day of the previous month.  
• Sponsor and/or family members are automatically reenrolled into the appropriate plan, but may choose to terminate enrollment from the TDP without completing the 12-month lock-in. Premium changes may apply. |
| A Selected Reserve of the Ready Reserve or IRR sponsor and/or family have been enrolled in the TDP for more than 30 days and sponsor called to active duty for more than 30 consecutive days and has enrolled him or herself and family in TDP more than 30 days prior to start of the active duty orders. | **Sponsor:**  
• TDP-enrolled sponsor enrollment is terminated effective on the first day of the active duty orders.  
• Upon deactivation, coverage will be automatically reinstated the day following status change and sponsor is responsible for completing the remaining months on his or her initial 12-month lock-in period.  
**Family Members:**  
• TDP-enrolled family members’ enrollment is terminated as of 11:59 p.m. on the last day of the month in which the sponsor changes status. If the sponsor changes status on the first day of the month, the last day of coverage is the last day of the previous month.  
• Family members are automatically reenrolled in the program as active duty family members with the lower premium rate.  
• Coverage continues under the existing 12-month lock-in period.  
• Premium rate returns to the appropriate Selected Reserve or IRR rate on the first of the month following the sponsor’s deactivation. |
**End-of-Eligibility Scenarios**

Figure 2.3 describes scenarios that will result in an end of TDP coverage due to loss of eligibility.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>When TRICARE Dental Program (TDP) Coverage Ends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsor retires or separates from active duty service.</td>
<td>The last day of coverage is the last day of the month in which the sponsor retires or separates. However, if the sponsor’s retirement or separation is on the first day of the month, the last day of coverage is the last day of the previous month. For example: If the sponsor retires on May 1, the last day of coverage is April 30.¹</td>
</tr>
<tr>
<td>Unmarried child turns age 21 (or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50% of the financial support).</td>
<td>The child loses eligibility as of 11:59 p.m. on the last day of the month in which the age limit is reached (or the education-related eligibility ends).</td>
</tr>
<tr>
<td>Spouse and sponsor divorce.</td>
<td>The spouse loses all eligibility based on his or her former marital status as of 11:59 p.m. on the last day of the month in which the divorce becomes final.</td>
</tr>
</tbody>
</table>

¹ Retired sponsors and family members may be eligible to enroll in the TRICARE Retiree Dental Program (TRDP). For more information about the TRDP, visit [www.tricare.mil/dental](http://www.tricare.mil/dental).

**TDP Survivor Benefit**

When a sponsor dies, the surviving spouse and children are eligible for the TDP Survivor Benefit. Spouses are eligible for three years beginning on the date of the sponsor’s death. Children remain eligible until age 21, or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provided over 50 percent of the financial support at the time of the sponsor’s death.

There is no requirement for surviving beneficiaries to have been enrolled in the TDP at the time of their sponsor’s death. The TDP Survivor Benefit also applies to family members of the Selected Reserve of the Ready Reserve and IRR (special mobilization category), regardless of whether the sponsor was on active duty orders or enrolled in the TDP at the time of his or her death.

**Note:** At the time of their sponsor’s death, enrollment of eligible surviving family members will automatically be terminated from the current TDP plan and will be reenrolled in the TDP Survivor Benefit. Survivors will be notified of this termination of enrollment and the terms of the TDP Survivor Benefit.

The government pays 100 percent of the TDP Survivor Benefit premium for the:

- Surviving spouse for up to three years from the sponsor’s date of death
- Surviving children until age 21, or 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provided over 50 percent of the financial support at the time of the sponsor’s death
- Incapacitated children for the greater of:
  - Three years from the sponsor’s date of death (not to exceed 21 years of age), or
  - The date the child turns 21 years of age, or
  - The date on which the child attains 23 years of age if enrolled in a full-time course of study at an approved institution of higher learning

Family members are still responsible for any applicable cost-shares associated with the TDP Survivor Benefit.

Once the three-year TDP Survivor Benefit period ends, surviving spouses are eligible for the TRICARE Retiree Dental Program (TRDP). The TRDP may also be available to surviving family members who do not qualify for the TDP Survivor Benefit. For more information about the TRDP, visit [www.tricare.mil/dental](http://www.tricare.mil/dental).
National Guard and Reserve Important Information

Dental Readiness Assessment for National Guard and Reserve

The Department of Defense has directed the uniformed services to require all National Guard and Reserve members to undergo an annual dental examination. The Department of Defense Active Duty/Reserve Forces Dental Examination form (DD Form 2813) will be used to assist TRICARE Dental Program (TDP)-enrolled National Guard and Reserve members in documenting dental health.

TDP network dentists will complete DD Form 2813 at no additional cost to TDP beneficiaries. The National Guard or Reserve member is responsible for obtaining the examination, providing the form to the dentist, and reporting the result to their service branch. DD Form 2813 is available to download at www.tricare.mil/dental.

National Guard and Reserve members are encouraged to contact their service branch representatives to determine their service-specific requirements for this document before scheduling annual dental examinations.

How the Sponsor’s Changing Status Affects Reenrollment Process

National Guard and Reserve sponsors may go on and off active duty several times throughout their careers. The TDP offers continuous coverage to National Guard and Reserve sponsors. However, prior to activation, your and your family’s TDP enrollment status will determine whether reenrollment is automatic or if it requires action on your part. Please remember that the premium rate applicable to you and your family can vary based upon your status.

National Guard and Reserve Sponsor Coverage

National Guard and Reserve sponsors are eligible to enroll in the TDP when they are not on active duty for more than 30 consecutive days. If a National Guard or Reserve sponsor enrolled in the TDP is called or ordered to active duty for more than 30 consecutive days, his or her enrollment will automatically be terminated from the program during the period of activation and he or she automatically will be reenrolled upon deactivation.

A National Guard or Reserve sponsor is not considered part of a family plan and can be enrolled even if the family is not enrolled. The sponsor also has a separate monthly premium.

National Guard and Reserve Family-Member Coverage

National Guard and Reserve family members can enroll in the TDP even if their sponsor does not enroll. The plan offers continuous dental coverage throughout the sponsor’s changing status—from inactive status to active status and back again. During a National Guard or Reserve sponsor’s activation, family members will enjoy reduced monthly premiums because they are considered active duty family members during that time. Additionally, because family-member enrollment is not dependent on the sponsor’s enrollment, family members can enroll in the TDP at any time.
The following coverage flowchart demonstrates how TDP coverage changes when a National Guard or Reserve sponsor’s status changes.

**National Guard and Reserve Activation/Deactivation Coverage Status**

<table>
<thead>
<tr>
<th>SPONSOR</th>
<th>FAMILY MEMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ENROLLED</strong> in individual TDP plan prior to activation</td>
<td><strong>ENROLLED</strong> in individual or family TDP plan (separate from sponsor) prior to sponsor’s activation</td>
</tr>
<tr>
<td><strong>ACTIVATED</strong> Sponsor disenrolled from TDP. Active duty benefits apply.</td>
<td></td>
</tr>
<tr>
<td><strong>DEACTIVATED</strong> Sponsor reenrolled in TDP automatically. Must complete the remainder of the 12-month minimum enrollment requirement.</td>
<td><strong>SPONSOR ACTIVATED</strong> Family members enrolled in individual or family plan within 30 days of sponsor activation (for specific contingency operations) pay the reduced premium rate.¹</td>
</tr>
<tr>
<td><strong>NOT ENROLLED</strong> in individual TDP plan prior to activation</td>
<td><strong>NOT ENROLLED</strong> in TDP plan prior to sponsor’s activation</td>
</tr>
<tr>
<td><strong>ACTIVATED</strong> Sponsor not eligible for TDP enrollment. Active duty benefits apply.</td>
<td><strong>SPONSOR ACTIVATED</strong> Family members who enroll in individual or family plan more than 30 days after sponsor activation, or whose sponsors are not activated for specific contingency operations, pay the reduced premium rate.¹</td>
</tr>
<tr>
<td><strong>DEACTIVATED</strong> Sponsor eligible for enrollment in TDP. Must complete the 12-month minimum enrollment requirement.</td>
<td><strong>SPONSOR DEACTIVATED</strong> Family members’ coverage continues uninterrupted at applicable National Guard and Reserve premium rate. Must complete remainder of 12-month minimum enrollment requirement.</td>
</tr>
<tr>
<td><strong>SPONSOR DEACTIVATED</strong> Family members’ coverage automatically canceled upon sponsor’s deactivation. Sponsor must notify the TDP contractor if family member reenrollment is desired.</td>
<td></td>
</tr>
</tbody>
</table>

1. Timing of enrollment affects minimum lock-in requirement, not premium rates.

Reduced Premium Rate: Government pays 60 percent, enrollee pays 40 percent
National Guard and Reserve Premium Rate: 100 percent non-government shared premium rate
Choosing a Dentist

**CONUS Dentists**

TRICARE Dental Program (TDP) beneficiaries residing in the CONUS service areas can receive dental care at civilian dental offices and visit any civilian dentist of choice provided they are appropriately licensed and authorized. However, receiving treatment from a TDP network dentist can save you money and paperwork.

**Network Dentists**

A TDP network dentist has signed a contractual agreement with the TDP contractor to follow TDP rules for providing care and accepting payments. When using a TDP network dentist, you should never pay more than the applicable cost-share for covered services subject to applicable maximums, limitations, and exclusions. TRICARE recommends you have your dentist submit a predetermination request when the cost is expected to be above $300. Specifically, TDP network dentists agree to:

- Accept the negotiated fee as payment in full, charging the family member only the applicable cost-share percentage. The negotiated fee is often lower than the normal rate charged by dentists in the area and, therefore, saves you money.

- Invoice the TDP contractor directly for its share of the bill, so you do not have to pay the dentist directly and await reimbursement.*

- Complete the claim form for you and submit it to TDP on your behalf.

- Participate in the TDP contractor’s quality-assurance programs.

- Provide any information needed by the TDP contractor to make coverage and payment determinations.

- Complete the *Department of Defense Active Duty/Reserve Forces Dental Examination* form (DD Form 2813) for National Guard and Reserve members.

*If the beneficiary chooses to not sign an assignment of benefits statement on the claim form, the provider may request reimbursement from the beneficiary up to their fee at time of treatment. In this case, the TDP contractor will issue any applicable reimbursement directly to the beneficiary.

To locate a TDP network dentist, please visit [uccitdp.com](http://uccitdp.com). It is important to remember to check with the dentist to make sure he or she still participates in the TDP network.

**Timely Appointments**

In CONUS locations, in most instances, there will be a network general dentist located within 35 driving miles of your home and you will be able to arrange an appointment within 21 days of your call to the dental office. If you are unable to obtain a first-available appointment with a general dentist within 21 days of your call and within 35 driving miles of your home, please reference the inside front cover of this booklet for CONUS contact information and details and the TDP contractor will assist you with scheduling. If the TDP contractor is unable to schedule an appointment within 21 days, you will be able to seek care from a non-TDP network dentist and the TDP contractor will pay the claim for that particular procedure in a manner that limits your out-of-pocket costs to approximately what they would be from a TDP network dentist.

**Non-network Dentists**

Dentists who have not signed a contract with the TDP contractor are considered non-network dentists. Non-network dentists may bill you the full fee. You will be responsible for paying the difference between the TDP contractor’s allowance and the amount charged by the non-network dentist, in addition to the applicable cost-share percentage. Also, non-network dentists may or may not submit claim forms to the TDP contractor on your behalf.

Non-network dentists are not required to accept direct payment from the TDP contractor. To send payment directly to a non-network dentist, you must sign an assignment of benefits statement on the claim form. This allows the TDP contractor to send payment to the non-network dentist and to notify the enrollee with a dental explanation of benefits. If the assignment of benefits provision is not signed, the TDP contractor’s payment will be sent to the enrollee, and he or she will be responsible for paying the dentist.
Ensure your dentist is a TDP network dentist by asking if he/she is in United Concordia’s TDP network. If the dentist is not in the TDP network, you may continue to receive care, but be aware that you may incur higher out-of-pocket costs.

If your dentist is interested in becoming a TDP network dentist, ask him or her to call the TDP contractor’s Customer Service Department at 1-844-653-4061 or visit www.uccitdp.com to obtain an application packet.

OCONUS Dentists

As a convenience to you, a directory of TRICARE OCONUS Preferred Dentists (TOPDs), including orthodontists, is available at www.uccitdp.com. TOPDs have agreed to the following:

• TOPDs will not require you to pay their full charge at the time of service—only your applicable cost-share, if any.
• TOPDs will complete and submit your claim forms to the TDP contractor.

Prior to initiating treatment for a dental procedure that requires a cost-share, or when the treatment plan is extensive or costly, it is recommended that you have your dentist submit a pre-determination request to the TDP contractor.

You are under no obligation to seek care from TOPDs. However, in OCONUS locations where they are available, you may find it more convenient to do so.

In OCONUS locations, the TDP network requirement for access to an appointment within 21 days and 35 driving miles does not apply.

Note: For any orthodontic service, OCONUS enrollees will need to obtain a Non-Availability and Referral Form (NARF) from their TRICARE Area Office, designated OCONUS points of contact before any orthodontic treatment can begin, and submit it with the claim form.
Your Costs and Fees

**Premiums**

The share of premium paid by the government varies based upon the sponsor’s status as follows:

<table>
<thead>
<tr>
<th>Beneficiary Category</th>
<th>Premium Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family members of active duty service members or active National Guard or Reserve sponsors</td>
<td>60% government 40% beneficiary</td>
</tr>
<tr>
<td>Selected Reserve of the Ready Reserve and Individual Ready Reserve (IRR) (special mobilization category) sponsors</td>
<td>60% government 40% beneficiary</td>
</tr>
<tr>
<td>IRR (non-special mobilization category) sponsors</td>
<td>100% beneficiary</td>
</tr>
<tr>
<td>Selected Reserve and IRR family members</td>
<td>100% beneficiary</td>
</tr>
<tr>
<td>Eligible Survivors</td>
<td>100% government</td>
</tr>
</tbody>
</table>

Premiums are paid for a full month of coverage. There are no circumstances when a partial premium can be paid. Premium rates change annually on May 1. Visit [www.tricare.mil/costs](http://www.tricare.mil/costs) for details.

**Direct Billing Process**

The following payment methods are available for sponsors with insufficient funds in their uniformed service payroll account.

- **Initial payment** for the first month of coverage can be made by credit card, debit card, check, or money order. Your credit or debit card payment can be completed quickly during the enrollment process on the Beneficiary Web Enrollment website accessible at [www.tricare.mil/bwe](http://www.tricare.mil/bwe), or over the phone at 1-844-653-4061 (CONUS) or 1-844-653-4060 (OCONUS).
- **Ongoing payments** can be made by credit card, debit card, or electronic funds transfer. You can set up or change your ongoing payment method.

Please reference the inside front cover of this booklet for TDP contractor contact information to get assistance regarding making a payment.

**Maximums**

The accumulation of charges against the annual maximum benefit, accidental maximum, and orthodontic lifetime maximum (OLM) benefit is based on the allowable charge, less any cost-shares, for covered dental services. The allowable charge is the amount the TDP contractor will pay the dentist for the particular procedure performed. For TDP network dentists it is the negotiated fee. For non-network dentists, it is the fee they charge subject to limitations based upon reasonable and customary fee ranges for dentists practicing in that area. The cost-share is the portion of the allowable charge you, the beneficiary, must pay. Only the amounts paid to beneficiaries or the dentist by the TDP contractor are counted against the maximum.

Please remember there are limitations and exclusions, which are covered in Section 6 of this booklet, that may impact the amount that will be paid by the TDP.

**Annual Maximum Benefit**

There is a $1,500 annual maximum benefit per beneficiary, per plan year for non-orthodontic services. Each plan year begins May 1 and ends
April 30. Payments for certain diagnostic and preventive services are not applied against the annual maximum. See Section 6 of this booklet for details. **Note:** Premium rates will change annually on May 1.

**Lifetime Maximum Benefit for Orthodontic Treatment**

For orthodontic treatment, there is a $1,750 Orthodontic Lifetime Maximum (OLM) benefit per beneficiary. Orthodontic diagnostic services will be applied to the $1,500 dental program annual maximum. See Section 7 of this booklet for details.

**Accidental Annual Maximum Benefit**

In addition to the annual maximum, there is a $1,200 accidental annual maximum per enrollee (applicable to dental care provided due to an accident and applicable cost-shares). An accident is defined as an injury that results in physical damage or injury to the teeth and/or supporting hard and soft tissues from extraoral blunt forces and not due to chewing or biting forces. Once the $1,200 accidental maximum is reached, benefits will be paid up to the annual $1,500 maximum, with applicable benefit limitations and cost-share amounts.

**OCONUS Maximums**

The maximums for the OCONUS service area are the same as the CONUS service area. In the OCONUS service area, the government will pay for any valid costs in excess of the TDP contractor’s allowable charge (allowed fee) up to the billed charge for all enrollees except Selected Reserve and IRR family members, IRR (other than special mobilization category) members, and/or those who are not command-sponsored.

The government will not pay for the portion of the enrollee’s maximum that has already been paid by the TDP contractor nor will the government pay for any costs once the maximum has been met.

**Note:** Only the TDP contractor’s allowed fee (or the dentist’s actual charge if lower) less the applicable cost-share is applied against the maximum.

**Cost-shares**

A cost-share is the amount an enrollee is required to pay for the services received. The TDP contractor payment is based upon the allowable charge (allowed fee) the TDP contractor will consider for a particular procedure performed. For TDP network dentists, it is the negotiated fee. For non-network dentists, it is the fee charged by the dentist, subject to limitations based upon reasonable and customary fee ranges for dentists practicing in that area. The percentage paid and the beneficiary’s cost-share depends on the type of dental service received and the sponsor’s pay grade as noted in Figure 5.2 on the following page.

Please remember there are limitations and exclusions, which are covered in Section 6 of this booklet, that may impact the amount that will be paid by the TDP.

**Note:** You can often reduce your out-of-pocket costs by seeing a TDP network dentist.

Please note the following:

- All enrolled beneficiaries are eligible for dental care in both the CONUS and OCONUS service areas. However, only command-sponsored enrollees pay the OCONUS cost-shares. All others will pay cost-shares as shown in the middle two columns of Figure 5.2 on the following page.
- The command-sponsored OCONUS cost-share arrangement does not apply for any services received in the CONUS service area, regardless of whether the beneficiary is returning to the CONUS service area on a permanent or temporary basis. Such claims will be paid based upon the CONUS cost-share formula (middle two columns of Figure 5.2)
- Non-command-sponsored beneficiaries and/or Selected Reserve and IRR family members and IRR (other than special mobilization category) members who receive dental care OCONUS are responsible for CONUS cost-shares (middle two columns of Figure 5.2) as well as any difference between the dentist’s actual charge and the TDP contractor’s allowed fee for treatment.
## Beneficiary Cost-Shares Summary Chart

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Cost-Share for Pay Grades E-1–E-4</th>
<th>Cost-Share for All Other Pay Grades (E-5 and above)</th>
<th>Cost-Share for OCONUS Command-Sponsored Beneficiaries¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Preventive²</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Sealants</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Basic restorative</td>
<td>20%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Endodontic</td>
<td>30%</td>
<td>40%</td>
<td>0%</td>
</tr>
<tr>
<td>Periodontic</td>
<td>30%</td>
<td>40%</td>
<td>0%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>30%</td>
<td>40%</td>
<td>0%</td>
</tr>
<tr>
<td>Miscellaneous services</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>(occlusal guard, athletic mouth guard)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other restorative</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Implant services</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Prosthodontic</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontic³</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

1. The cost-shares noted above for OCONUS Command-Sponsored Beneficiaries do not apply to Selected Reserve of the Ready Reserve and Individual Ready Reserve (IRR) family members and IRR (other than special mobilization category) members. Beneficiaries in this category and/or non-command-sponsored members are subject to CONUS cost-share arrangement as noted in the two middle columns above.

2. Space maintainers are fully covered for patients under age 19. Sealants are fully covered as noted.

3. Orthodontic treatment is available for enrolled family members (non-spouse) up to, but not including, age 21, or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50 percent of the financial support. Orthodontic treatment is also available for spouses, National Guard and Reserve members up to, but not including, age 23. In all cases, coverage is effective until the end of the month in which the member reaches the applicable age limit. For example, if the member reaches the applicable age limit on April 1, they are covered through April 30.
TRICARE Dental Program Benefits and Exclusions

General Policies

All covered services are subject to the following general policies:

1. All premium payments must be paid to date in order for claims to be processed for payment. If the premiums are not current, it will result in the delay or denial of claims.

2. Services must be necessary and meet accepted standards of dental practice. Services determined to be unnecessary or do not meet accepted standards of practice are not billable to the patient by a network dentist unless the dentist notifies the patient of his or her liability prior to treatment and the patient chooses to receive the treatment. Network dentists shall document such notification to the patient in his or her records.

3. An appeal is not available when the services are determined to be unnecessary or do not meet accepted standards of dental practice unless the dentist notifies the patient of his or her liability prior to treatment and the patient chooses to receive the treatment. This is because such services are not billable to the patient, and there would be no amount in dispute to consider at appeal. The patient notification must be specific to the dental treatment and cannot be a general financial agreement.

4. Medical procedures, as well as procedures covered as adjunctive dental care under a TRICARE medical policy, are not covered under the TRICARE Dental Program (TDP).

5. Procedures should be reported using the American Dental Association’s® current dental procedure codes and terminology. Note: For OCONUS claims, if a procedure code is not given, a complete description of the service performed, including applicable tooth numbers, should be provided.

6. Claims submitted for payment more than 12 months after the month in which a service is provided are not eligible for payment. A network dentist may not bill the beneficiary for services that are denied for this reason.

7. Services, including evaluations, that are routinely performed in conjunction with or as part of another service are considered integral. Network dentists may not bill patients for denied services if they are considered integral to another service.

8. OCONUS services that are considered integral to another service and are submitted on the same OCONUS claims with the corresponding definitive service, then the integral service fee will be added into the fee for the definitive service and only the definitive service is processed on the OCONUS claim for payment. The payment allowance will be up to the 95th percentile of the District of Columbia for the definitive procedure.

9. Network dentists may not bill the TDP contractor or the patient for the completion of claim forms and submission of required information for determination of benefits.

10. Infection-control procedures and fees associated with Occupational Safety and Health Administration and/or other governmental agency compliance are considered part of the dental services provided and may not be billed separately by a network dentist.

11. Local anesthesia is considered integral to the procedure(s) for which it is provided.

12. Payment for diagnostic services performed in conjunction with orthodontics is applied to the patient’s annual maximum, subject to the note under Figure 6.1.

13. Time periods for routine oral exams, prophylaxes (cleanings), bitewing X-rays, and topical fluoride treatments are based on the month of service and are measured backward from the date of the most recent service in each category. These time periods are not related to the standard May–April plan year, and may vary based on each beneficiary’s coverage effective date.

For example: If a member enrolls in the TDP in May 2017 and receives a cleaning on May 13, 2017, and again on January 10, 2018, he or
she would be eligible for the next cleaning on May 1, 2018. If he or she chooses to have a cleaning in April 2018, that would be the third cleaning within a consecutive 12-month period and would not be an allowable charge. The third cleaning in a 12-month period would not be covered since it is in excess of the two allowable cleanings in a consecutive 12-month period (except as allowed in the case of a third cleaning during pregnancy).

14. The 24-month limitation for periodontal services (for example, osseous surgery) is based on the exact date of service (day and month) when the procedure was performed. For example: If scaling and root planing was performed on September 10, 2017, scaling and root planing in the same area of the mouth would not be eligible until September 10, 2019.

15. The 36-month time limitation for a panoramic or complete series of X-rays or a denture reline/rebase is calculated to the month in which the service was performed. For example: If an enrollee received a complete series of X-rays on May 15, 2017, he or she would be eligible for another complete series of X-rays, or a panoramic X-ray, on May 1, 2020.

16. The 36-month time limitation for sealants is based on the exact date of service (month and day) when the service was performed. For example: If a sealant was received on June 11, 2017, a replacement sealant would not be eligible until June 11, 2020.

17. The five-year time limitation for other restorative services (for example, crowns, onlays,) and prosthodontic services (for example, dentures, fixed bridges,) is based on the exact date of service (day and month) when the procedure was performed. For example: If a fixed partial denture was placed on June 15, 2017, a replacement denture would not be eligible until June 15, 2022.

18. For reporting and benefit purposes, the completion date for crowns, inlays, onlays, buildups, posts and cores, or fixed prostheses is the cementation date.

19. For reporting and benefit purposes, the completion date for removable prostheses is the insertion date.

20. For reporting and benefit purposes, the completion date for endodontic therapy is the date the tooth is sealed.

21. Payment will not be made for crowns, inlays, onlays, posts and cores, or dentures/bridges initiated prior to the effective date of the patient’s coverage.

If you have any questions about benefit periods and eligibility, please reference the inside front cover of this booklet for the TDP customer service contact information and details.

**Documentation Required for Specific Services**

Some covered procedures require the submission of diagnostic materials, such as periodontal charting, X-rays, and/or a brief narrative report of the specific service(s) performed and any factors that may have affected the care provided. Where applicable, these requirements are indicated on the list of covered procedures. If X-rays are required, the TDP contractor will request that dentists submit all X-rays used for diagnosis and treatment planning.

It is the TDP contractor’s intent to request only those X-rays that are generally taken as part of diagnosis and treatment planning. If, for some reason, X-rays were not taken or are not available, a brief explanation should be included with the claim.

“**Report required**” means that these services will be paid only when accompanied by detailed documented circumstances and must be submitted with the claim.

“**Periodontal charting required**” means that complete periodontal charting must be submitted for review at the time of claim submission.

**Note:** For OCONUS claims, the submission of X-rays and periodontal charting is not required unless specifically requested by the TDP contractor. All claims received from the OCONUS service area will be processed without a “report” requirement.
### Diagnostic Services

#### Diagnostic Services Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation—established patient</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation—problem-focused</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under age 3 and counseling with primary caregiver</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation—new or established patient</td>
</tr>
<tr>
<td>D0160 R</td>
<td>Detailed and extensive oral evaluation—problem-focused, by report</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation—new or established patient</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral—complete series (including bitewings)</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral—periapical first film</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral—periapical—each additional film</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral—occlusal film</td>
</tr>
<tr>
<td>D0250</td>
<td>Extraoral—2D projection radiographic image</td>
</tr>
<tr>
<td>D0251</td>
<td>Extraoral—posterior dental radiographic image</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing—single film</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings—two films</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings—three films</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings—four films</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic film</td>
</tr>
<tr>
<td>D0340</td>
<td>Cephalometric film</td>
</tr>
<tr>
<td>D0425</td>
<td>Caries susceptibility tests</td>
</tr>
</tbody>
</table>

\( R = \text{Report required.} \)

1. Payments for these services are not applied against the beneficiary’s annual maximum benefit.

**Note:** Patient-specific rationale (specific signs or symptoms) is required when submitting a claim for a panoramic film or full series of X-rays for a patient under age 5.


### Benefits and Limitations for Diagnostic Services

1. Three oral evaluations (D0120, D0150, or D0180) are covered in a consecutive 12-month period. Only two of these oral evaluations may be from the same office. A third oral evaluation is covered only if it is rendered by a different office. A comprehensive periodontal evaluation will be considered integral if provided on the same date of service, by the same dentist, as any other oral evaluation.

2. Comprehensive evaluations (D0150) are only eligible:
   - For new patients
   - For patients who have not had an oral evaluation within the previous 36 months from the same office
   - On an exception basis, by report, for patients who have had a significant change in health conditions or other unusual circumstances

3. Three oral evaluations (D0145) for patients under age 3 are covered in a consecutive 12-month period. Only two of these oral evaluations (D0145) may be from the same office. A third oral evaluation (D0145) is covered only if it is rendered by a different office. However, the total number of evaluations (D0145, D0150, D0120) for a patient under age 3 in a consecutive 12-month period cannot exceed a total of three evaluations.

4. One comprehensive periodontal evaluation (D0180) will be allowed per patient per consecutive 12-month period per office. A comprehensive periodontal evaluation will be considered integral if provided on the same date of service by the same dentist as any other oral evaluation.

5. Limited oral evaluation, problem-focused (D0140), is eligible once per patient per dentist in a consecutive 12-month period in conjunction with consultations (D9310)—only one of these services is eligible within a consecutive 12-month period. A limited oral evaluation will be considered integral when provided on the same date of service, by the same dentist, as any other oral evaluation.

6. Reevaluations are considered integral procedures.
7. Detailed and extensive oral evaluations, problem-focused (D0160), are only payable by report upon review and are limited to once per patient per dentist, per the life of the contract. They will not be paid if related to non-covered medical, dental, or adjunctive dental procedures.

8. X-rays that are not of diagnostic quality are not covered and may not be charged to the patient when provided by a network dentist.

9. One full mouth X-ray (complete series or panoramic X-ray) is covered in a 36-month period.

10. Panoramic and full mouth X-rays are not routinely covered for patients under age 5 unless approved by the TDP contractor. Patient-specific rationale (specific signs or symptoms) must be submitted for review. If denied, a network dentist cannot charge a fee to the patient.

11. One set of bitewing X-rays, consisting of up to four bitewing X-rays per visit, is covered during a consecutive 12-month period.

12. A second set of bitewing X-rays, consisting of up to four bitewing X-rays, is covered at the gaining location if the patient moves as a result of a permanent change of station (PCS) relocation at least 40 miles from the original servicing location. A copy of the sponsor’s official relocation orders must be submitted with the claim. If a copy of the relocation orders cannot be obtained, a letter from the sponsor’s immediate commanding officer or documentation from the sponsor’s local uniformed services personnel office confirming the location change may be submitted.

13. Vertical bitewings (D0277) will be paid at the same allowance as four bitewings and are subject to the same benefit limitations as four bitewing X-rays. The patient is not responsible for the difference between the allowance and the dentist’s charge.

14. X-rays are not a covered benefit when taken by an X-ray laboratory, unless billed by a licensed participating dentist. Any difference between the allowance for the X-rays and the fee charged by the X-ray laboratory cannot be charged to the patient.

15. If the total allowance for individually reported periapical, occlusal, and/or bitewing X-rays equals or exceeds the allowance for a complete series, the individually listed X-rays are paid as a complete series and are subject to the same benefit limitations as a complete series. A network dentist may not charge any difference in fees to the patient.

16. Periapical and/or bitewing X-rays are considered integral when performed on the same date of service, by the same dentist, as a complete series of X-rays.

17. Bitewing X-rays are not considered integral when performed on the same date of service as a panoramic X-ray. They are paid as a separate service.

18. Payment for individually reported periapical X-rays and a panoramic X-ray will be limited to the payment allowance for a complete series of X-rays.

19. The X-ray taken to diagnose the need for a root canal is eligible for payment in addition to the root canal therapy. All other X-rays taken within 30 days of the root canal therapy and in conjunction with the root canal therapy, including post-treatment films, are considered integral and should not be billed separately.

20. X-rays are not covered when performed in conjunction with the diagnosis or treatment of temporomandibular joint dysfunction (TMD).

21. 2D radiographic image (D0250), extraoral posterior radiographic image (D0251) and 2D cephalometric radiographic image (D0340) are each covered once per 12-month period. They are not covered for the diagnosis or treatment of TMD.

22. Cephalometric films are covered for patients under age 23, and only when provided for orthodontics.

23. Pulp vitality tests are considered integral to all services.

24. Caries susceptibility tests are payable only in conjunction with an intensive regimen of home preventive therapy (including prescription mouth rinses) to determine if the therapy should be continued. The test is payable once per enrollee per lifetime. The regimen must have been initiated immediately following completion of restorative care for a recent episode of rampant caries.
25. Caries susceptibility tests are not payable on a routine basis for patients with unrestored carious lesions or when performed for patient education.

**Preventive Services**

**Preventive Services Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110¹</td>
<td>Prophylaxis—adult</td>
</tr>
<tr>
<td>D1120¹</td>
<td>Prophylaxis—child</td>
</tr>
<tr>
<td>D1206¹</td>
<td>Topical fluoride varnish</td>
</tr>
<tr>
<td>D1208¹</td>
<td>Topical application of fluoride — excluding varnish</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer—fixed—unilateral</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer—fixed—bilateral</td>
</tr>
<tr>
<td>D1520</td>
<td>Space maintainer—removable—unilateral</td>
</tr>
<tr>
<td>D1525</td>
<td>Space maintainer—removable—bilateral</td>
</tr>
<tr>
<td>D1550</td>
<td>Recementation of space maintainer</td>
</tr>
<tr>
<td>D1555</td>
<td>Removal of fixed space maintainer</td>
</tr>
<tr>
<td>D1575</td>
<td>Distal shoe space maintainer—fixed—unilateral</td>
</tr>
<tr>
<td>D1999</td>
<td>Unspecified preventive procedure, by report</td>
</tr>
</tbody>
</table>

1. Payments for these services are not applied against the beneficiary’s annual maximum benefit.


**Benefits and Limitations for Preventive Services**

1. Two routine prophylaxes are covered in a consecutive 12-month period.
2. A third prophylaxis is covered in a consecutive 12-month period during pregnancy. Enrollees should speak with their dentists to ensure that pregnancy is noted clearly on the claim form.
3. Adult prophylaxes will be allowed on patients age 13 and older.
4. A third prophylaxis in a consecutive 12-month period is allowed for an enrollee diagnosed with diabetes, coronary artery disease (heart), cerebral vascular disease (stroke), rheumatoid arthritis, lupus, oral cancer and recipients of an organ transplant. The dentist must indicate the medical diagnosis code on the claim form. Enrollees should ensure that the medical diagnosis is noted clearly on the claim form.
5. Routine prophylaxes may be allowed when eligible and when performed by the same dentist on the same day as one partial quadrant scaling and root planing (D4342) or one partial quadrant periodontal surgery (D4211, D4241, D4261) because the remaining healthy teeth in the remaining quadrants still may need prophylaxes. The prophylaxis will be paid separately when one limited site is provided and will be considered integral if more than one limited site is provided.
6. A routine prophylaxis is considered integral when performed in conjunction with or as a finishing procedure to periodontal scaling and root planing, periodontal maintenance, gingivectomy or gingivoplasty, gingival flap procedure, mucogingival surgery, or osseous surgery.
7. A routine prophylaxis includes associated scaling and polishing procedures. There are no provisions for any additional allowance based on degree of difficulty.
8. Two topical fluoride applications are covered in a consecutive 12-month period.
9. Topical fluoride applications, which may include fluoride varnish applications, are covered only when a prescription-strength fluoride product designed solely for use in the dental office is used and delivered to the teeth under the direct supervision of a dental professional. The use of a prophylaxis paste containing fluoride qualifies for payment only as a component of a routine prophylaxis.
10. Space maintainers and distal shoe space maintainers (D1575) are fully covered without cost shares for patients under age 19. Coverage is limited to posterior teeth.
11. Repair of a damaged space maintainer is not a covered benefit.
12. Recementation or rebonding of a space maintainer is covered once per 12-month period. Recementation or rebonding provided within 12 months of placement by the same dentist is considered integral.
13. Removal of a space maintainer is considered an integral procedure, unless performed by a different dentist who is not a member of the same practice that placed the space maintainer.

**Sealants**

**Sealants Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1351</td>
<td>Sealant—per tooth</td>
</tr>
<tr>
<td>D1352</td>
<td>Preventive resin restoration in a moderate-to-high caries risk patient—permanent tooth</td>
</tr>
<tr>
<td>D1353</td>
<td>Sealant repair – per tooth</td>
</tr>
<tr>
<td>D1354</td>
<td>Interim caries arresting medicament application</td>
</tr>
</tbody>
</table>


**Benefits and Limitations for Sealants**

1. Sealants are only covered on permanent molars through age 18. The teeth must be caries free with no previous restoration on the mesial, distal, or occlusal surfaces. One sealant per tooth is covered in a three-year period.

2. Sealants and sealant repairs for teeth other than permanent molars are not covered.

3. Sealants provided on the same date of service and the same tooth as a restoration of the occlusal surface are considered integral procedures.

4. Preventive resin restoration (D1352) on first and second permanent molars is covered as a preventive service at the same benefit level as a dental sealant (D1351). Also, the service is covered to the same age limit and frequency limit as dental sealants with a combined frequency limitation with dental sealants (D1351).

5. Interim caries arresting medicament application (D1354) is covered as preventive service through age 18. It is paid as a mouth procedure, not per tooth. The frequency limit is once per mouth per three-year period, regardless of the number of teeth treated.

**Restorative Services**

**Restorative Services Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam—one surface, primary or permanent</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam—two surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam—three surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam—four or more surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite—one surface, anterior</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite—two surfaces, anterior</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite—three surfaces, anterior</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite—four or more surfaces or involving incisal angle (anterior)</td>
</tr>
<tr>
<td>D2390</td>
<td>Resin-based composite crown, anterior</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin-based composite—one surface, posterior</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite—two surfaces, posterior</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite—three surfaces, posterior</td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless-steel crown—primary tooth</td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated stainless-steel crown—permanent tooth</td>
</tr>
<tr>
<td>D2932</td>
<td>Prefabricated resin crown</td>
</tr>
<tr>
<td>D2933</td>
<td>Prefabricated stainless-steel crown with resin window</td>
</tr>
<tr>
<td>D2951</td>
<td>Pin retention—per tooth, in addition to restoration</td>
</tr>
</tbody>
</table>


**Benefits and Limitations for Restorative Services**

1. Diagnostic casts (study models) taken in conjunction with restorative procedures are considered integral.
2. Sedative restorations are not a covered benefit.
3. Pin retention is covered only when reported in conjunction with an eligible restoration.
4. An amalgam or resin restoration reported with a crown buildup or post and core is considered an integral procedure.
5. An amalgam or resin restoration reported with a pin (D2951), in addition to a crown, is considered a pin buildup (D2950).
6. Preventive resin restorations or other restorations that do not extend into the dentin are considered sealants for purposes of reporting and determining benefits.
7. Restorative services are covered only when necessary due to decay, tooth fracture, attrition, erosion, abrasion, or congenital or developmental defects. Restorative services are not covered when performed for cosmetic purposes.
8. For purposes of determining benefits, a restoration involving two or more surfaces will be processed using the appropriate multiple-surface restoration code.
9. Multiple restorations performed on the same surface of a posterior tooth without involvement of a second surface, on the same date and by the same dentist, will be processed as a single-surface restoration.
10. If multiple posterior restorations involving multiple surfaces with at least one common surface are reported, an allowance will be made for a single restoration reflecting the number of different surfaces involved.
11. Multiple restorations involving contiguous (touching) surfaces provided on the same date of service by the same dentist will be processed as one restoration reflective of the number of different surfaces reported. For example: A one-surface amalgam restoration of the lingual surface, and a one-surface amalgam restoration of the mesial surface will be combined and processed as a two-surface amalgam restoration. This policy applies regardless of restorations being reported as separate services.
12. Repair or replacement of restorations by the same dentist and involving the same tooth surfaces performed within 12 months of the previous restoration are considered integral procedures, and a separate fee is not chargeable to the enrollee by a network dentist. However, payment may be allowed if the repair or replacement is due to fracture of the tooth or the restoration involves the occlusal surface of a posterior tooth or the lingual surface of an anterior tooth and is placed following root canal therapy.
13. Resin (composite) restorations on greater than three surfaces are not covered when performed on posterior teeth. However, an allowance will be made for a comparable amalgam restoration. The enrollee is responsible for the difference between the dentist’s charge for the resin restoration and the amount paid by the TDP contractor for the amalgam restoration.
14. Restorations are not covered when performed after the placement of any type of crown or onlay on the same tooth and by the same dentist, unless approved by the TDP contractor.
15. The payment for restorations includes all related services including, but not limited to, etching, bases, liners, dentinal adhesives, local anesthesia, polishing, caries removal, preparation of gingival tissue, occlusal/contact adjustments, and detection agents.
16. Resin-based composite crowns (D2390) placed on anterior teeth are limited to one per tooth per 12-month period. Repair or replacement within 12 months of placement by the same dentist is considered integral. Placement within 12 months of a previous restoration is not covered. A separate fee is not chargeable to the patient by a network dentist. If a diagnosis warrants placement of a crown (D2390) on a tooth that has been previously restored within the last 12 months by the same dentist, the service may be considered for coverage. A report justifying the procedure must be submitted for review by the TDP contractor. The payment for restorations includes all related services, including, but not limited to, etching, bases, liners, dentinal adhesives, local anesthesia, polishing, and caries removal, preparation of gingival tissue, occlusal/contact adjustments, and detection agents.
17. Prefabricated resin crowns (D2932) are covered once per tooth, per lifetime, only on anterior primary teeth, anterior permanent teeth through age 14, or when placed as the result of accidental
injury. They are considered integral when placed in preparation for a permanent crown.

18. Prefabricated stainless-steel crowns (D2930, D2931) are covered only on primary teeth, permanent teeth through age 14, or when placed as a result of accidental injury. They are limited to one per patient, per tooth, per lifetime.

19. Prefabricated stainless-steel crowns with resin windows (D2933) are covered only on primary anterior and premolar teeth at any age, and on permanent anterior and premolar teeth of patients age 14 and younger. They are limited to one per tooth, per lifetime.

20. Prefabricated esthetic-coated stainless-steel crowns—primary tooth (D2934)—are not covered. However, an allowance will be made for a comparable prefabricated stainless-steel crown—primary tooth (D2930). The beneficiary is responsible for the difference between the dentist’s charge for the esthetic-coated stainless-steel crown and the amount paid by the TDP contractor for the stainless-steel crown.

Other Restorative Services Codes (continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2751 X</td>
<td>Crown—porcelain-fused to predominantly base metal</td>
</tr>
<tr>
<td>D2752 X</td>
<td>Crown—porcelain-fused to noble metal</td>
</tr>
<tr>
<td>D2780 X</td>
<td>Crown—3/4 cast high-noble metal</td>
</tr>
<tr>
<td>D2781 X</td>
<td>Crown—3/4 cast predominantly base metal</td>
</tr>
<tr>
<td>D2782 X</td>
<td>Crown—3/4 cast noble metal</td>
</tr>
<tr>
<td>D2783 X</td>
<td>Crown—3/4 porcelain/ceramic</td>
</tr>
<tr>
<td>D2790 X</td>
<td>Crown—full-cast high-noble metal</td>
</tr>
<tr>
<td>D2791 X</td>
<td>Crown—full-cast predominantly base metal</td>
</tr>
<tr>
<td>D2792 X</td>
<td>Crown—full-cast noble metal</td>
</tr>
<tr>
<td>D2794 X</td>
<td>Crown—titanium</td>
</tr>
<tr>
<td>D2910</td>
<td>Recement inlay, onlay, or partial coverage restoration</td>
</tr>
<tr>
<td>D2915</td>
<td>Recement cast or prefabricated post and core</td>
</tr>
<tr>
<td>D2920</td>
<td>Recement crown</td>
</tr>
<tr>
<td>D2941</td>
<td>Interim therapeutic restoration—primary dentition</td>
</tr>
<tr>
<td>D2950 X</td>
<td>Core buildup, including pins</td>
</tr>
<tr>
<td>D2954 X</td>
<td>Prefabricated post and core in addition to crown</td>
</tr>
<tr>
<td>D2960 X</td>
<td>Labial veneer (resin laminate)—chairside</td>
</tr>
<tr>
<td>D2961 X</td>
<td>Labial veneer (resin laminate)—laboratory</td>
</tr>
<tr>
<td>D2962 XR</td>
<td>Labial veneer—porcelain laminate—laboratory</td>
</tr>
<tr>
<td>D2980</td>
<td>Crown repair necessitated by restorative material failure</td>
</tr>
<tr>
<td>D2982</td>
<td>Onlay repair necessitated by restorative material failure</td>
</tr>
<tr>
<td>D2983</td>
<td>Veneer repair necessitated by restorative material failure</td>
</tr>
</tbody>
</table>

X = X-ray required. R = Report required.

Go to www.health.mil/military-health-topics/business-support/rates-and-reimbursement/tdp-supplement for the most updated list of dental codes for other restorative services.
Benefits and Limitations for Other Restorative Services

1. For reporting and benefit purposes, the completion date for crowns, onlays, and buildups is the cementation date.

2. The charge for a crown or onlay should include all charges for work related to its placement, including, but not limited to, preparation of gingival tissue, tooth preparation, temporary crown, diagnostic casts (study models), impressions, try-in visits, and cementations of both temporary and permanent crowns.

3. Onlays, permanent single-crown restorations, and posts and cores for enrollees age 12 or younger are excluded from coverage, unless specific rationale is provided indicating the reason for such treatment (for example, fracture, endodontic therapy) and is approved by the TDP contractor.

4. Core buildups (D2950) can be considered for benefits only when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler used to eliminate any undercut, box form or concave irregularity in preparation.

5. Indirectly fabricated posts and cores (D2952) are processed as an alternate benefit of a prefabricated post and core. The patient is responsible for the difference between the dentist’s charge for the indirectly fabricated post and core and the amount paid by the TDP contractor for the prefabricated post and core.

6. Additional posts (D2953, D2957) are considered integral to the associated restorative procedure.

7. Replacement of crowns, onlays, buildups, and posts and cores is covered only if the existing crown, onlay, buildup, or post and core was inserted at least five years prior to the replacement and satisfactory evidence is presented that the existing crown, onlay, buildup, or post and core is not and cannot be made serviceable. The five-year limitation on crowns, onlays, buildups, and posts and cores does not apply if the enrollee moves as a result of a PCS relocation at least 40 miles from the original servicing location. Satisfactory evidence must show that the existing crown, onlay, buildup, or post and core is not and cannot be made serviceable, and a copy of the sponsor’s official relocation orders must be submitted with the claim. If a copy of the relocation orders cannot be obtained, a letter from the sponsor’s immediate commanding officer or documentation from the sponsor’s local uniformed services personnel office confirming the location change may be submitted. The five-year service date is measured based on the actual date (for example, day and month) of the initial service, rather than the first day of the month during which the initial service was received. The PCS exception does not apply if the enrollee returns to the previous provider for treatment.

8. Onlays, crowns, and posts and cores are covered only when necessary due to decay or tooth fracture. However, if the tooth can be adequately restored with amalgam or composite (resin) filling material, payment will be made as an alternate benefit for that service. This payment can be applied toward the cost of the onlay, crown, or post and core. This provision only applies where the restorative service provided is due to decay or tooth fracture. If the service is being provided for some other purpose (for example, aesthetics), an alternate service, such as an amalgam or composite filling, would not be eligible for payment.

9. Crowns, inlays, onlays, buildups, or posts and cores begun prior to the effective date of coverage or cemented after the cancellation date of coverage are not eligible for payment.

10. Onlays are eligible only when a cusp(s) is overlaid.

11. Temporary crowns placed in preparation for a permanent crown are considered integral to the placement of the permanent crown.

12. Recementation or rebonding of single prosthetics (D2910, D2915, D2920) is eligible once per 12-month period. Recementation or rebonding provided within 12 months of placement by the same dentist is considered integral.

13. When performed as an independent procedure, the placement of a post is not a covered benefit. Posts are only covered when provided as part of a buildup for a crown and are considered integral to the buildup.
14. Diagnostic pretreatment X-rays will be requested for codes (D2960, D2961, D2962) in order to determine if the service is cosmetic or due to fracture/decay or severe developmental or congenital disfigurement.

15. Payment for an anterior resin restoration will be made when a laboratory-fabricated porcelain or resin veneer is used to restore anterior teeth due to tooth fracture or caries.

16. Porcelain veneers (D2962) may be considered for coverage for fully erupted anterior teeth to correct severe developmental or congenital disfigurement. A report must be submitted that describes the disfigurement. Payment will be limited to once per tooth per five-year period.

17. Labial veneers are covered only when placed to treat severe developmental or congenital disfigurement. However, if a restoration is necessary due to tooth fracture or decay, payment may be made for an anterior resin restoration toward the cost of the veneer, and the patient is responsible for any difference between the allowance for a resin restoration and the dentist’s charge for the veneer. Treatment of peg lateral incisors is covered as long as the method of restoration (labial veneer or crown) is a TDP-covered procedure.

18. Porcelain ceramic, metallic, and composite resin inlays are not covered benefits. However, payment will be made for a corresponding amalgam restoration for a posterior tooth reflective of the number of different surfaces restored.

19. Glass ionomer restorations will be paid based upon the fees for amalgam restorations for posterior teeth or resin restorations for anterior teeth.

20. Interim therapeutic restoration of the primary dentition (D2941) involves the placement of an adhesive restorative material following caries debridement by hand or other method for the management of early childhood caries, and is not considered a definitive restoration. They are limited to once per tooth per lifetime, regardless of surface treated. If a permanent restoration is placed on the same tooth, same surface, by the same dentist within 12 months following the interim therapeutic restoration, it will be offset by the payment made for the interim therapeutic restoration.

21. Repairs to crowns, inlays and onlays (D2980, D2982, D2983) are covered once per tooth, per 24-month period.

### Endodontic Services

#### Endodontic Services Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3120</td>
<td>Pulp cap—indirect (excluding final restoration)</td>
</tr>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration)</td>
</tr>
<tr>
<td>D3221</td>
<td>Pulpal debridement—primary and permanent teeth</td>
</tr>
<tr>
<td>D3222</td>
<td>Partial pulpotomy for apexogenesis—permanent tooth with incomplete root development</td>
</tr>
<tr>
<td>D3230</td>
<td>Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3240</td>
<td>Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3310</td>
<td>Anterior root canal (excluding final restoration)</td>
</tr>
<tr>
<td>D3320</td>
<td>Bicuspid root canal (excluding final restoration)</td>
</tr>
<tr>
<td>D3330</td>
<td>Molar root canal (excluding final restoration)</td>
</tr>
<tr>
<td>D3332 XR</td>
<td>Incomplete endodontic therapy; inoperable, unrestorable, or fractured tooth</td>
</tr>
<tr>
<td>D3333 XR</td>
<td>Internal root repair of perforation defects</td>
</tr>
<tr>
<td>D3346</td>
<td>Retreatment of previous root canal therapy—anterior</td>
</tr>
<tr>
<td>D3347</td>
<td>Retreatment of previous root canal therapy—bicuspid</td>
</tr>
<tr>
<td>D3348</td>
<td>Retreatment of previous root canal therapy—molar</td>
</tr>
<tr>
<td>D3351</td>
<td>Apexification/recalcification/pulpal regeneration—initial visit (for example, apical closure/calcific repair of perforations, root resorption, pulp space disinfection)</td>
</tr>
</tbody>
</table>
### Endodontic Services Codes (continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3352</td>
<td>Apexification/recalcification/pulpal regeneration—interim medication replacement (for example, apical closure/calcific repair of perforations, root resorption, pulpal space disinfection)</td>
</tr>
<tr>
<td>D3353</td>
<td>Apexification/recalcification—final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption)</td>
</tr>
<tr>
<td>D3355</td>
<td>Pulpal regeneration – initial visit</td>
</tr>
<tr>
<td>D3356</td>
<td>Pulpal regeneration – interim medication replacement</td>
</tr>
<tr>
<td>D3357</td>
<td>Pulpal regeneration – completion of treatment</td>
</tr>
<tr>
<td>D3410</td>
<td>Apicoectomy/periradicular surgery—anterior</td>
</tr>
<tr>
<td>D3421</td>
<td>Apicoectomy/periradicular surgery—bicuspid (first root)</td>
</tr>
<tr>
<td>D3425</td>
<td>Apicoectomy/periradicular surgery—molar (first root)</td>
</tr>
<tr>
<td>D3426</td>
<td>Apicoectomy/periradicular surgery (each additional root)</td>
</tr>
<tr>
<td>D3427</td>
<td>Periradicular surgery without apicoectomy</td>
</tr>
<tr>
<td>D3428</td>
<td>Bone graft in conjunction with periradicular surgery – per tooth, single site</td>
</tr>
<tr>
<td>D3429</td>
<td>Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site</td>
</tr>
<tr>
<td>D3430</td>
<td>Retrograde filling—per root</td>
</tr>
<tr>
<td>D3432</td>
<td>Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery</td>
</tr>
<tr>
<td>D3450</td>
<td>Root amputation—per root</td>
</tr>
<tr>
<td>D3920 X</td>
<td>Hemisection (including any root removal)—not including root canal therapy</td>
</tr>
</tbody>
</table>

\[X = \text{X-ray required.}\]
\[R = \text{Report required.}\]

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### Benefits and Limitations for Endodontic Services

1. Direct pulp caps are considered an integral service when provided on the same date as a restoration.
2. Indirect pulp caps are considered integral when provided within 60 days prior to the final restoration. When covered, payment is limited to one indirect pulp cap per tooth per lifetime.
3. Pulpotomies are considered integral when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
4. A pulpotomy is covered when performed as a final endodontic procedure and is payable generally on primary teeth only. Pulpotomies performed on permanent teeth are considered integral to root canal therapy and are not reimbursable unless specific rationale is provided and root canal therapy is not and will not be provided on the same tooth.
5. Pulpal therapy (resorbable filling) is covered as follows:
   - Limited to primary incisor teeth for enrollees up to, but not including, age 6, and primary molars and cuspids up to, but not including, age 11
   - Covered once per tooth per lifetime
   - Payment for the pulpal therapy will be offset by the allowance for a pulpotomy provided within 45 days preceding pulpal therapy on the same tooth by the same dentist
6. Pulpal debridement is covered when provided to relieve acute pain. It is considered integral to root canal therapy or palliative emergency treatment when provided on the same day by the same dentist.
7. Partial pulpotomy for apexogenesis is covered on permanent teeth only, once per tooth per lifetime. The procedure is considered integral when performed on the same day or within 45 days prior to root canal therapy.
8. Treatment of a root canal obstruction is considered an integral procedure.
9. Incomplete endodontic therapy is not covered when due to the patient discontinuing treatment. All other circumstances require a pretreatment X-ray and a report describing

the treatment provided and why it could not be completed.

10. Retreatment of previous root canal therapy (D3346, D3347, D3348) is not covered within the first 12 months of initial treatment if performed by the same dentist. A network dentist cannot charge a fee to the enrollee.

11. Internal root repair of a perforation defect is not covered when the dentist providing the treatment causes the perforation. All other circumstances require a pretreatment X-ray and a report.

12. The placement of a post is not covered when provided as an independent procedure. Posts are eligible only when provided as part of a crown buildup and are considered integral to the buildup.

13. Canal preparation and fitting of a preformed dowel or post (D3950) is not a covered benefit.

14. For reporting and benefit purposes, the completion date for endodontic therapy is the date the tooth is sealed.

15. No allowance is made for the treatment of additional canals.

16. An “open and drain” performed on an abscessed tooth to relieve pain in an emergency is considered palliative emergency treatment (D9110).

17. Placement of a final restoration following endodontic therapy is eligible as a separate procedure.

18. Apexification/recalcification/pulpal regeneration initial visit (D3351) includes opening tooth, preparation of canal spaces, first replacement of medication and necessary radiographs. (This procedure may include the first phase of complete root canal therapy.)

19. Apexification/recalcification/pulpal regeneration interim medication replacement code (D3352) includes visits where the intra-canal medication is replaced with new medication and necessary radiographs. There may be several of these visits.

20. The apexification final visit (D3353) includes the last phase of complete root canal therapy. Root canal therapy reported in addition to apexification treatment is not a separately reimbursable procedure.

21. Pulpal regeneration (D3355) includes opening tooth, preparation of canal spaces, and placement of medication. (D3357) does not include final restoration. Covered once per tooth, per lifetime, and only for patients under age 15.

22. Endodontic therapy provided within 12 months following pulpal regeneration by the same office requires submission of a pre-treatment x-ray, postoperative endodontic film, and a report detailing the patient’s condition.

23. Bone grafts (D3428, D3429) are covered once per tooth per lifetime.

24. Hemisection (D3920) requires submission of a pre-treatment x-ray.

**Periodontal Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210 XC</td>
<td>Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4211 XC</td>
<td>Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4240 XC</td>
<td>Gingival flap procedure, including root planing—four or more contiguous teeth or bound teeth spaces per quadrant</td>
</tr>
<tr>
<td>D4241 XC</td>
<td>Gingival flap procedure, including root planing—one to three contiguous teeth or bound teeth spaces per quadrant</td>
</tr>
<tr>
<td>D4249 X</td>
<td>Clinical crown lengthening—hard tissue</td>
</tr>
<tr>
<td>D4260 XC</td>
<td>Osseous surgery (including flap entry and closure)—four or more contiguous teeth or bound teeth spaces per quadrant</td>
</tr>
<tr>
<td>D4261</td>
<td>Osseous surgery (including flap entry and closure)—one to three contiguous teeth or bound teeth spaces per quadrant</td>
</tr>
<tr>
<td>D4263 XC</td>
<td>Bone replacement graft—retained natural tooth—first site in quadrant</td>
</tr>
<tr>
<td>D4264 XC</td>
<td>Bone replacement graft—retained natural tooth—each additional site in quadrant</td>
</tr>
<tr>
<td>D4266 XC</td>
<td>Guided tissue regeneration—resorbable barrier, per site</td>
</tr>
<tr>
<td>D4267 XC</td>
<td>Guided tissue regeneration—nonresorbable barrier, per site (includes membrane removal)</td>
</tr>
<tr>
<td>D4270 C</td>
<td>Pedicle soft-tissue graft procedure</td>
</tr>
</tbody>
</table>
## Periodontal Services Codes (continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4273 C</td>
<td>Autogenous connective tissue graft (including donor and recipient sites) first tooth, implant or edentulous tooth position in graft.</td>
</tr>
<tr>
<td>D4275 C</td>
<td>Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft.</td>
</tr>
<tr>
<td>D4276 C</td>
<td>Combined connective tissue and doubled pedicle graft, per tooth</td>
</tr>
<tr>
<td>D4277 C</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft.</td>
</tr>
<tr>
<td>D4278 C</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site.</td>
</tr>
<tr>
<td>D4283 C</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site.</td>
</tr>
<tr>
<td>D4285 C</td>
<td>Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site.</td>
</tr>
<tr>
<td>D4341 XC</td>
<td>Periodontal scaling and root planing—four or more teeth per quadrant (See “Note” below)</td>
</tr>
<tr>
<td>D4342 XC</td>
<td>Periodontal scaling and root planing—one to three teeth per quadrant (See “Note” below)</td>
</tr>
<tr>
<td>D4346</td>
<td>Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.</td>
</tr>
<tr>
<td>D4355</td>
<td>Full-mouth debridement to enable comprehensive evaluation and diagnosis, covered once per 24-month period.</td>
</tr>
<tr>
<td>D4910</td>
<td>Periodontal maintenance</td>
</tr>
<tr>
<td>D4920</td>
<td>Unscheduled dressing change (by someone other than treating dentist)</td>
</tr>
</tbody>
</table>

X = X-ray required.
C = Periodontal charting required.

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**Note:** For procedures that required X-rays or periodontal charting, a diagnosis should also be provided. X-rays and periodontal charting are required when submitting a claim for periodontal scaling and root planing (D4341, D4342) for all enrollees. An exception is made for periodontists; they do not have to submit x-rays and charting on a prepayment basis.

For beneficiaries diagnosed with diabetes, coronary artery disease, cerebral vascular disease, rheumatoid arthritis, lupus, oral cancer or organ transplant patients (medically documented), no cost-shares will apply to scaling and root planing procedures, as per periodontal services benefits and limitations. Annual payment maximum is not affected by these procedures.

### Benefits and Limitations for Periodontal Services

1. Gingivectomy or gingivoplasty, gingival flap procedure, guided-tissue regeneration, soft-tissue grafts, bone-replacement grafts, and osseous surgery provided within 24 months of the same surgical periodontal procedure, in the same area of the mouth, are not covered.

2. Gingivectomy or gingivoplasty performed in conjunction with the placement of crowns, onlays, crown buildups, posts and cores, or basic restorations are considered integral to the restoration.

3. Surgical periodontal procedures or scaling and root planing in the same area of the mouth within 24 months of a gingival flap procedure are not covered.

4. Gingival flap procedure is considered integral when provided on the same date of service by the same dentist in the same area of the mouth as periodontal surgical procedures (except periodontal bone grafts), endodontic procedures, and oral surgery procedures.

5. Pretreatment X-rays will be required for crown-lengthening benefit determinations and if the crown lengthening is completed on
the same date as the crown, it is considered integral to the crown.

6. A free soft-tissue graft (D4277) procedure (including donor site surgery), first tooth or edentulous tooth position in the same graft site and an autogenous connective-tissue graft (D4273) site will be processed as a one-site benefit when the graft(s) area includes two contiguous teeth.

7. Autogenous connective tissue grafts (D4273 and D4283) and combined connective tissue and double pedicle grafts (D4276) are covered and payable by sites when approved by the contractor.

8. A soft tissue graft is considered integral when provided on the same date of service by the same dentist in the same mouth area as osseous surgery.

9. Bone-replacement grafts (D4263, D4264) are not to be reported for an edentulous space or an extraction site. A bone graft within 24 months of a bone graft on the same tooth is not covered.

10. A single site for reporting bone-replacement grafts consists of one contiguous area, regardless of the number of teeth (for example, crater) or surfaces involved. Another site on the same tooth is considered integral to the first site reported. Noncontiguous areas involving different teeth may be reported as additional sites.

11. Osseous surgery is not covered when provided within 24 months of osseous surgery in the same area of the mouth.

12. Osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same dentist, and in the same area of the mouth is considered an integral procedure.

13. One crown lengthening per tooth, per lifetime, is covered.

14. Guided tissue regeneration is only covered when provided to treat specific types of periodontal defects (for example, Class II furcation involvements or interbony defects). The tooth/teeth must be present in order for this procedure to be eligible. It is not covered when provided to obtain root coverage, or when provided in conjunction with (same or different date as) extractions, cyst removal, or procedures involving the removal of a portion of a tooth such as an apicoectomy or hemisection.

15. Periodontal scaling and root planing is a benefit when there is loss of attachment due to periodontal disease. X-rays and periodontal charting are required for review for all members. (An exception is made for periodontists; they do not have to submit x-rays and charting on a prepayment basis.)

16. Periodontal scaling and root planing provided within 24 months of periodontal scaling and root planing or periodontal surgical procedures in the same area of the mouth is not covered.

17. Patients diagnosed with diabetes, coronary artery disease (heart), cerebral vascular disease (stroke), rheumatoid arthritis, lupus, oral cancer and recipients of an organ transplant are covered for up to four quadrants of periodontal scaling and root planing with no cost-share. These procedures will not count toward the annual maximum. Other scaling and root planing limitations still apply, including the 24 month periodicity. Beneficiaries should speak to their dental providers to ensure that their diabetes diagnosis is noted clearly on the claim form.

18. A routine prophylaxis is considered integral when performed in conjunction with or as a finishing procedure to periodontal scaling and root planing, periodontal maintenance, gingivectomy or gingivoplasty, gingival flap procedure, or osseous surgery.

19. Up to four periodontal maintenance procedures, or any combination of routine prophylaxes and periodontal maintenance procedures totaling four, may be paid within a consecutive 12-month period.

20. Periodontal maintenance is generally covered when performed following active periodontal treatment.

21. Periodontal maintenance provided on the same day as periodontal scaling and root planing is considered integral.

22. An oral evaluation reported in addition to periodontal maintenance will be processed as a separate procedure subject to the policy and limitations applicable to oral evaluations.
23. Payment for multiple periodontal surgical procedures (except soft tissue grafts, osseous grafts, and guided tissue regeneration) provided in the same area of the mouth during the same course of treatment is based on the fee for the greater surgical procedure. The lesser procedure is considered integral and its allowance is included in the allowance for the greater procedure. When both bone grafts and guided-tissue regenerations are submitted for the same site, both procedures are eligible for benefits if approved by the contractor.

24. Procedures related to the placement of an implant (for example, bone recontouring and excision of gingival tissue) are not covered.

25. Surgical revision procedure (D4268) is considered integral to all other periodontal procedures.

26. Full-mouth debridement to enable comprehensive evaluation and diagnosis (D4355) is covered once within a consecutive 24-month period.

27. Full-mouth debridement to enable comprehensive evaluation and diagnosis provided on the same day as scaling and root planing, periodontal maintenance, or routine prophylaxis is considered integral.

**Prosthodontic Services**

**Prosthodontics, Removable Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>Complete denture—maxillary</td>
</tr>
<tr>
<td>D5120</td>
<td>Complete denture—mandibular</td>
</tr>
<tr>
<td>D5130</td>
<td>Immediate denture—maxillary</td>
</tr>
<tr>
<td>D5140</td>
<td>Immediate denture—mandibular</td>
</tr>
<tr>
<td>D5211</td>
<td>Maxillary partial denture—resin base (including conventional clasps, rests, and teeth)</td>
</tr>
<tr>
<td>D5212</td>
<td>Mandibular partial denture—resin base (including conventional clasps, rests, and teeth)</td>
</tr>
<tr>
<td>D5213</td>
<td>Maxillary partial denture—cast-metal framework with resin denture bases (including conventional clasps, rests, and teeth)</td>
</tr>
</tbody>
</table>

**Prosthodontics, Removable Services Codes (continued)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5214</td>
<td>Mandibular partial denture—cast-metal framework with resin denture bases (including conventional clasps, rests, and teeth)</td>
</tr>
<tr>
<td>D5221</td>
<td>Immediate maxillary partial denture—resin base (including any conventional clasps, rests, and teeth)</td>
</tr>
<tr>
<td>D5222</td>
<td>Immediate mandibular partial denture—resin base (including any conventional clasps, rests, and teeth)</td>
</tr>
<tr>
<td>D5223</td>
<td>Immediate maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)</td>
</tr>
<tr>
<td>D5224</td>
<td>Immediate mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)</td>
</tr>
<tr>
<td>D5225</td>
<td>Maxillary partial denture—flexible base (including any clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5226</td>
<td>Mandibular partial denture—flexible base (including any clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5410</td>
<td>Adjust complete denture—maxillary</td>
</tr>
<tr>
<td>D5411</td>
<td>Adjust complete denture—mandibular</td>
</tr>
<tr>
<td>D5421</td>
<td>Adjust partial denture—maxillary</td>
</tr>
<tr>
<td>D5422</td>
<td>Adjust partial denture—mandibular</td>
</tr>
<tr>
<td>D5510</td>
<td>Repair broken complete denture base</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken teeth—complete denture (each tooth)</td>
</tr>
<tr>
<td>D5610</td>
<td>Repair resin denture base</td>
</tr>
<tr>
<td>D5620</td>
<td>Repair cast framework</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken clasp</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth—per tooth</td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
</tr>
<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture</td>
</tr>
<tr>
<td>D5670</td>
<td>Replace all teeth and acrylic on cast-metal framework (maxillary)</td>
</tr>
<tr>
<td>D5671</td>
<td>Replace all teeth and acrylic on cast-metal framework (mandibular)</td>
</tr>
<tr>
<td>D5710</td>
<td>Rebase complete maxillary denture</td>
</tr>
<tr>
<td>D5711</td>
<td>Rebase complete mandibular denture</td>
</tr>
<tr>
<td>D5720</td>
<td>Rebase maxillary partial denture</td>
</tr>
<tr>
<td>D5721</td>
<td>Rebase mandibular partial denture</td>
</tr>
<tr>
<td>Code</td>
<td>Description of Service</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>D5730</td>
<td>Reline complete maxillary denture (chairside)</td>
</tr>
<tr>
<td>D5731</td>
<td>Reline complete mandibular denture (chairside)</td>
</tr>
<tr>
<td>D5740</td>
<td>Reline maxillary partial denture (chairside)</td>
</tr>
<tr>
<td>D5741</td>
<td>Reline mandibular partial denture (chairside)</td>
</tr>
<tr>
<td>D5750</td>
<td>Reline complete maxillary denture (laboratory)</td>
</tr>
<tr>
<td>D5751</td>
<td>Reline complete mandibular denture (laboratory)</td>
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<tr>
<td>D5760</td>
<td>Reline maxillary partial denture (laboratory)</td>
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<tr>
<td>D5761</td>
<td>Reline mandibular partial denture (laboratory)</td>
</tr>
<tr>
<td>D5810</td>
<td>Interim complete denture (maxillary)</td>
</tr>
<tr>
<td>D5811</td>
<td>Interim complete denture (mandibular)</td>
</tr>
<tr>
<td>D5820</td>
<td>Interim partial denture (maxillary)</td>
</tr>
<tr>
<td>D5821</td>
<td>Interim partial denture (mandibular)</td>
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<tr>
<td>D5850</td>
<td>Tissue conditioning (maxillary)</td>
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<tr>
<td>D5851</td>
<td>Tissue conditioning (mandibular)</td>
</tr>
<tr>
<td>D5863</td>
<td>Overdenture – complete maxillary</td>
</tr>
<tr>
<td>D5864</td>
<td>Overdenture – partial maxillary</td>
</tr>
<tr>
<td>D5865</td>
<td>Overdenture – complete mandibular</td>
</tr>
<tr>
<td>D5866</td>
<td>Overdenture – partial mandibular</td>
</tr>
</tbody>
</table>

**Prosthodontics, Fixed Services**

**Prosthodontics, Fixed Services Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6210 X</td>
<td>Pontic—cast high-noble (gold) metal</td>
</tr>
<tr>
<td>D6211 X</td>
<td>Pontic—cast predominantly base (lead) metal</td>
</tr>
<tr>
<td>D6212 X</td>
<td>Pontic—cast noble metal</td>
</tr>
<tr>
<td>D6214 X</td>
<td>Pontic—titanium</td>
</tr>
<tr>
<td>D6240 X</td>
<td>Pontic—porcelain fused to high-noble metal (porcelain over gold)</td>
</tr>
<tr>
<td>D6241 X</td>
<td>Pontic—porcelain fused to predominantly base metal</td>
</tr>
<tr>
<td>D6242 X</td>
<td>Pontic—porcelain fused to noble metal</td>
</tr>
<tr>
<td>D6245 X</td>
<td>Pontic—porcelain/ceramic</td>
</tr>
</tbody>
</table>

**Prosthodontics, Fixed Services Codes (continued)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6545 X</td>
<td>Retainer—cast metal for resin-bonded fixed prosthesis</td>
</tr>
<tr>
<td>D6548 X</td>
<td>Retainer—porcelain/ceramic for resin-bonded fixed prosthesis</td>
</tr>
<tr>
<td>D6549 X</td>
<td>Resin retainer – for resin bonded fixed prosthesis</td>
</tr>
<tr>
<td>D6600 X</td>
<td>Retainer inlay—porcelain/ceramic, two surfaces</td>
</tr>
<tr>
<td>D6601 X</td>
<td>Retainer inlay—porcelain/ceramic, three or more surfaces</td>
</tr>
<tr>
<td>D6602 X</td>
<td>Retainer inlay—cast high-noble metal, two surfaces</td>
</tr>
<tr>
<td>D6603 X</td>
<td>Retainer inlay—cast high-noble metal, three or more surfaces</td>
</tr>
<tr>
<td>D6604 X</td>
<td>Retainer inlay—cast predominantly base metal, two surfaces</td>
</tr>
<tr>
<td>D6605 X</td>
<td>Retainer inlay—cast predominantly base metal, three or more surfaces</td>
</tr>
<tr>
<td>D6606 X</td>
<td>Retainer inlay—cast noble metal, two surfaces</td>
</tr>
<tr>
<td>D6607 X</td>
<td>Retainer inlay—cast noble metal, three or more surfaces</td>
</tr>
<tr>
<td>D6608 X</td>
<td>Retainer Onlay—porcelain/ceramic, two surfaces</td>
</tr>
<tr>
<td>D6609 X</td>
<td>Retainer Onlay—porcelain/ceramic, three or more surfaces</td>
</tr>
<tr>
<td>D6610 X</td>
<td>Retainer Onlay—cast high-noble metal, two surfaces</td>
</tr>
<tr>
<td>D6611 X</td>
<td>Retainer Onlay—cast high-noble metal, three or more surfaces</td>
</tr>
<tr>
<td>D6612 X</td>
<td>Retainer Onlay—cast predominantly base metal, two surfaces</td>
</tr>
<tr>
<td>D6613 X</td>
<td>Retainer Onlay—cast predominantly base metal, three or more surfaces</td>
</tr>
<tr>
<td>D6614 X</td>
<td>Retainer Onlay—cast noble metal, two surfaces</td>
</tr>
<tr>
<td>D6615 X</td>
<td>Retainer Onlay—cast noble metal, three or more surfaces</td>
</tr>
<tr>
<td>D6624 X</td>
<td>Retainer inlay—titanium</td>
</tr>
<tr>
<td>D6634 X</td>
<td>Retainer Onlay—titanium</td>
</tr>
<tr>
<td>D6740 X</td>
<td>Retainer Crown—porcelain/ceramic</td>
</tr>
<tr>
<td>D6750 X</td>
<td>Retainer Crown—porcelain fused to high-noble metal</td>
</tr>
</tbody>
</table>
Prosthodontics, Fixed Services Codes (continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6751 X</td>
<td>Retainer Crown—porcelain fused to predominantly base metal</td>
</tr>
<tr>
<td>D6752 X</td>
<td>Retainer Crown—porcelain fused to noble metal</td>
</tr>
<tr>
<td>D6780 X</td>
<td>Retainer Crown—3/4 cast high-noble metal</td>
</tr>
<tr>
<td>D6781 X</td>
<td>Retainer Crown—3/4 cast predominantly base metal</td>
</tr>
<tr>
<td>D6782 X</td>
<td>Retainer Crown—3/4 cast noble metal</td>
</tr>
<tr>
<td>D6783 X</td>
<td>Retainer Crown—3/4 porcelain/ceramic</td>
</tr>
<tr>
<td>D6790 X</td>
<td>Retainer Crown—full-cast high-noble metal</td>
</tr>
<tr>
<td>D6791 X</td>
<td>Retainer Crown—full-cast predominantly base metal</td>
</tr>
<tr>
<td>D6792 X</td>
<td>Retainer Crown—full-cast noble metal</td>
</tr>
<tr>
<td>D6794 X</td>
<td>Retainer Crown—titanium</td>
</tr>
<tr>
<td>D6930</td>
<td>Recement or re-bond fixed partial denture</td>
</tr>
<tr>
<td>D6980</td>
<td>Fixed partial denture repair, necessitated by restorative material failure</td>
</tr>
</tbody>
</table>

X = X-ray required.  
R = Report required.

3. Removable cast-base partial dentures for enrollees under age 12 are excluded from coverage unless specific rationale is provided indicating the necessity for that treatment and is approved by the TDP contractor.

4. Flexible base partial dentures (D5225 and D5226) are a covered benefit. An alternate benefit is not applied.

5. Tissue conditioning is considered integral when performed on the same day as the delivery of a denture or a reline/rebase.

6. Recementation or rebonding of fixed prosthetics (D6930) is eligible once per 12-month period. Recementation or rebonding provided within 12 months of placement by the same dentist is considered integral.

7. Adjustments provided within six months of the insertion of an initial or replacement denture are integral to the denture.

8. The relining or rebasing of a denture, including immediate dentures, is considered integral when performed within six months following the insertion of that denture by the same dentist.

9. A reline/rebase is covered once in any 36-month period.

10. Fixed partial dentures, buildups, and posts and cores for enrollees under age 16 are not covered unless specific rationale is provided indicating the necessity for such treatment and is approved by the TDP contractor.

11. Payment for a denture or an overdenture made with precious metals is based on the allowance for a conventional denture. Any additional cost is the patient’s responsibility.

12. Specialized procedures performed in conjunction with an overdenture are not covered.

13. Provisional prostheses are designed for use over a limited period of time, after which they are replaced by a more definitive prosthesis. Interim complete and partial dentures are only covered once in a 12-month period.

14. Cast unilateral removable partial dentures are not covered benefits.

15. Indirectly fabricated posts and cores are processed as an alternate benefit of prefabricated posts and cores. The patient is responsible for the difference between the


Benefits and Limitations for Prosthodontic Services

1. For reporting and benefit purposes, the completion date for crowns and fixed partial dentures is the cementation date. The completion date for removable prosthodontic appliances is the insertion date. For immediate dentures, however, the provider who fabricated the dentures may be reimbursed for the dentures after insertion if another provider inserted the dentures.

2. The fee for diagnostic casts (study models) fabricated in conjunction with prosthetic and restorative procedures are included in the fee for these procedures. A separate fee is not chargeable to the enrollee by a network dentist.
dentist’s charge for the indirectly fabricated post and core and the allowance for the prefabricated post and core.

16. Precision attachments, personalization, precious-metal bases, and other specialized techniques are not covered.

17. Temporary fixed partial dentures are not a covered benefit and, when done in conjunction with permanent fixed partial dentures, are considered integral to the allowance for the fixed partial dentures.

18. Replacement of removable prostheses (D5110 through D5226), and fixed prostheses (D6210 through D6794), buildups, and posts and cores is covered only if the existing removable and/or fixed prostheses, buildup, or post and core were inserted at least five years prior to the replacement and satisfactory evidence is presented that the existing removable and/or fixed prostheses cannot be made serviceable. The five-year limitation on existing removable prostheses and/or fixed prostheses does not apply if the enrollee moves as a result of PCS relocation at least 40 miles from the original servicing location. Satisfactory evidence must show that the existing removable prostheses and/or fixed prostheses cannot be made serviceable, and a copy of the sponsor’s official relocation orders must be submitted with the claim. If a copy of the relocation orders cannot be obtained, a letter from the sponsor’s immediate commanding officer or documentation from the sponsor’s local uniformed service personnel office confirming the location change may be submitted. The five-year limitation is measured based on the actual date (for example, day and month) of the initial service, rather than the first day of the month during which the initial service was received. The PCS exception does not apply if the enrollee returns to the previous provider for treatment.

19. Removable or fixed prostheses initiated prior to the effective date of coverage or inserted/cemented after the cancellation date of coverage are not eligible for payment.

20. Replacement of all teeth and acrylic on a cast-metal framework (D5670, D5671) is covered once per arch per five-year period. Previous payment for this procedure or another denture within five years precludes payment for D5670 or D5671.

21. Repairs to removable and fixed dentures (D5510, D5520, D5610, D5620, D5630, D5640, D5650, D5660, D6980) are each covered once per mouth area, per 24-month period.

### Implant Services Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6010</td>
<td>Surgical placement of implant body—endosteal implant</td>
</tr>
<tr>
<td>D6013 R</td>
<td>Surgical placement of mini implant</td>
</tr>
<tr>
<td>D6050</td>
<td>Surgical placement—transosteal implant</td>
</tr>
<tr>
<td>D6052</td>
<td>Semi-precision attachment abutment</td>
</tr>
<tr>
<td>D6056</td>
<td>Prefabricated abutment—including placement</td>
</tr>
<tr>
<td>D6057</td>
<td>Custom abutment—including placement</td>
</tr>
<tr>
<td>D6058</td>
<td>Abutment-supported porcelain/ceramic crown</td>
</tr>
<tr>
<td>D6059</td>
<td>Abutment-supported porcelain fused to metal crown (high-noble metal)</td>
</tr>
<tr>
<td>D6060</td>
<td>Abutment-supported porcelain fused to metal crown (predominantly base metal)</td>
</tr>
<tr>
<td>D6061</td>
<td>Abutment-supported porcelain fused to metal crown (noble metal)</td>
</tr>
<tr>
<td>D6062 X</td>
<td>Abutment-supported cast metal crown (high-noble metal)</td>
</tr>
<tr>
<td>D6063</td>
<td>Abutment-supported cast metal crown (predominantly base metal)</td>
</tr>
<tr>
<td>D6064</td>
<td>Abutment-supported cast-metal crown (noble metal)</td>
</tr>
<tr>
<td>D6065</td>
<td>Implant-supported porcelain/ceramic crown</td>
</tr>
<tr>
<td>D6066</td>
<td>Implant-supported porcelain fused to metal crown (titanium, titanium alloy, high-noble metal)</td>
</tr>
<tr>
<td>D6067</td>
<td>Implant-supported metal crown (titanium, titanium alloy, high-noble metal)</td>
</tr>
<tr>
<td>D6068</td>
<td>Abutment-supported retainer for porcelain/ceramic full partial denture (FPD)</td>
</tr>
<tr>
<td>D6069</td>
<td>Abutment-supported retainer for porcelain fused to metal FPD (high-noble metal)</td>
</tr>
</tbody>
</table>
### Implant Services Codes (continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6070</td>
<td>Abutment-supported retainer for porcelain fused to metal FPD (predominantly base metal)</td>
</tr>
<tr>
<td>D6071</td>
<td>Abutment-supported retainer for porcelain fused to metal FPD (noble metal)</td>
</tr>
<tr>
<td>D6072</td>
<td>Abutment-supported retainer for cast-metal FPD (high-noble metal)</td>
</tr>
<tr>
<td>D6073</td>
<td>Abutment-supported retainer for cast-metal FPD (predominantly base metal)</td>
</tr>
<tr>
<td>D6074</td>
<td>Abutment-supported retainer for cast-metal FPD (noble metal)</td>
</tr>
<tr>
<td>D6075</td>
<td>Implant-supported retainer for ceramic FPD</td>
</tr>
<tr>
<td>D6076</td>
<td>Implant-supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)</td>
</tr>
<tr>
<td>D6077</td>
<td>Implant-supported retainer for cast-metal FPD (titanium, titanium alloy, or high noble metal)</td>
</tr>
<tr>
<td>D6081</td>
<td>Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure</td>
</tr>
<tr>
<td>D6090 R</td>
<td>Repair implant-supported prosthesis, by report</td>
</tr>
<tr>
<td>D6092</td>
<td>Recement-implant/abutment-supported crown</td>
</tr>
<tr>
<td>D6093</td>
<td>Recement-implant/abutment-supported fixed partial denture</td>
</tr>
<tr>
<td>D6094</td>
<td>Abutment-supported crown—(titanium)</td>
</tr>
<tr>
<td>D6095 R</td>
<td>Repair implant abutment, by report</td>
</tr>
<tr>
<td>D6101 X</td>
<td>Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of exposed implant surfaces, including flap entry and closure</td>
</tr>
<tr>
<td>D6102 X</td>
<td>Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant, and surface cleaning of exposed implant surfaces, including flap entry and closure</td>
</tr>
<tr>
<td>D6103 X</td>
<td>Bone graft for repair of peri-implant defect – does not include flap entry and closure</td>
</tr>
<tr>
<td>D6104</td>
<td>Bone graft at time of implant placement</td>
</tr>
<tr>
<td>D6110</td>
<td>Implant/abutment supported removable denture for edentulous arch-maxillary</td>
</tr>
<tr>
<td>D6111</td>
<td>Implant abutment supported removable denture for edentulous arch-mandibular</td>
</tr>
</tbody>
</table>

### Implant Services Codes (continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6112</td>
<td>Implant/abutment supported removable denture for partially edentulous arch-maxillary</td>
</tr>
<tr>
<td>D6113</td>
<td>Implant/abutment supported removable denture for partially edentulous arch-mandibular</td>
</tr>
<tr>
<td>D6114</td>
<td>Implant/abutment supported fixed denture for edentulous arch-maxillary</td>
</tr>
<tr>
<td>D6115</td>
<td>Implant/abutment supported fixed denture for edentulous arch-mandibular</td>
</tr>
<tr>
<td>D6116</td>
<td>Implant/abutment supported fixed denture for partially edentulous arch-maxillary</td>
</tr>
<tr>
<td>D6117</td>
<td>Implant/abutment supported fixed denture for partially edentulous arch-mandibular</td>
</tr>
<tr>
<td>D6194</td>
<td>Abutment-supported retainer crown for FPD—(titanium)</td>
</tr>
</tbody>
</table>

*Note:* When submitting a claim for codes D7230 and D7240, x-rays and report are required only for patients under age 15 or over age 30.


### Benefits and Limitations for Implant Services

1. Implant services are subject to a 50 percent cost-share and the annual program maximum.
2. Implant services are not eligible for enrollees under age 14 unless submitted with X-rays and approved by the TDP contractor.
3. Mini implants are covered by report, only to support a complete denture for edentulous patients. A maximum of 4 per arch per lifetime are covered.
4. Replacement of implants is covered only if the existing implant was placed at least five years prior to the replacement and the implant has failed.
5. Replacement of implant prosthetics is covered only if the existing prosthetics were placed at least five years prior to the replacement.
and satisfactory evidence is presented that demonstrates they are not, and cannot be made, serviceable.

6. Repair of an implant-supported prosthesis (D6090) and repair of an implant abutment (D6095) are only payable by report upon the TDP contractor review. The report should describe the problem and how it was repaired.

7. Recementation or rebonding of an implant/abutment-supported crown (D6092) is covered once 12-month period. Recementation or rebonding provided within 12 months of placement by the same dentist is considered integral.

8. Recementation of an implant/abutment-supported fixed-partial denture (D6093) is eligible once per 12-month period. Recementation or rebonding provided within 12 months of placement by the same dentist is considered integral.

9. Semi-precision attachment abutment (D6052) includes placement of keeper assembly.

10. Scaling and debridement (D6081) is not to be performed in conjunction with D1110 or D4910.

11. Bone grafts (D6103, D6104) are covered once per tooth, per lifetime.

**Oral Surgery Services**

**Oral Surgery Services Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants—deciduous tooth</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
</tr>
<tr>
<td>D7210</td>
<td>Extraction of erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap, if indicated</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth—soft tissue</td>
</tr>
<tr>
<td>D7230 XR</td>
<td>Removal of impacted tooth—partially bony. See “Note” below</td>
</tr>
<tr>
<td>D7240 XR</td>
<td>Removal of impacted tooth—completely bony. See “Note” below</td>
</tr>
<tr>
<td>D7241 XR</td>
<td>Removal of impacted tooth—completely bony, with unusual surgical complications</td>
</tr>
<tr>
<td>D7250</td>
<td>Removal of residual tooth roots (cutting procedure)</td>
</tr>
<tr>
<td>D7251 XR</td>
<td>Coronecotomy—intentional partial tooth removal</td>
</tr>
<tr>
<td>D7260</td>
<td>Oroantral fistula closure</td>
</tr>
<tr>
<td>D7261</td>
<td>Primary closure of a sinus perforation</td>
</tr>
<tr>
<td>D7270</td>
<td>Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</td>
</tr>
<tr>
<td>D7280</td>
<td>Exposure of an unerupted tooth</td>
</tr>
<tr>
<td>D7283</td>
<td>Placement of device to facilitate eruption of impacted tooth</td>
</tr>
<tr>
<td>D7285</td>
<td>Biopsy of oral tissue—hard (bone, tooth)</td>
</tr>
<tr>
<td>D7286</td>
<td>Biopsy of oral tissue—soft (all others)</td>
</tr>
<tr>
<td>D7290</td>
<td>Surgical repositioning of teeth</td>
</tr>
<tr>
<td>D7291</td>
<td>Transseptal fiberotomy/supra crestal fiberotomy, by report</td>
</tr>
<tr>
<td>D7310</td>
<td>Alveoloplasty in conjunction with extractions—four or more teeth or tooth spaces per quadrant</td>
</tr>
<tr>
<td>D7320</td>
<td>Alveoloplasty not in conjunction with extractions—four or more teeth or tooth spaces per quadrant</td>
</tr>
<tr>
<td>D7321</td>
<td>Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces per quadrant</td>
</tr>
<tr>
<td>D7471</td>
<td>Removal of lateral exostosis—maxilla or mandible</td>
</tr>
<tr>
<td>D7472</td>
<td>Removal of torus palatinus</td>
</tr>
<tr>
<td>D7473</td>
<td>Removal of torus mandibularis</td>
</tr>
<tr>
<td>D7485</td>
<td>Reduction of osseous tuberosity</td>
</tr>
<tr>
<td>D7510</td>
<td>Incision and drainage of abscess—infraoral soft tissue</td>
</tr>
<tr>
<td>D7511 R</td>
<td>Incision and drainage of abscess—infraoral soft tissue—complicated (includes drainage of multiple fascial spaces)</td>
</tr>
<tr>
<td>D7910</td>
<td>Suture of recent small wounds—up to 5 cm</td>
</tr>
<tr>
<td>D7911</td>
<td>Complicated suture—up to 5 cm</td>
</tr>
<tr>
<td>D7912 R</td>
<td>Complicated suture—greater than 5 cm</td>
</tr>
<tr>
<td>D7953 R</td>
<td>Bone replacement graft for ridge preservation—per site</td>
</tr>
</tbody>
</table>
Oral Surgery Services Codes (continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7960</td>
<td>Frenulectomy—also known as frenectomy or frenotomy—separate procedure not incidental to another procedure</td>
</tr>
<tr>
<td>D7963</td>
<td>Frenuloplasty</td>
</tr>
<tr>
<td>D7971</td>
<td>Excision of pericoronal gingiva</td>
</tr>
<tr>
<td>D7972</td>
<td>Surgical reduction of fibrous tuberosity</td>
</tr>
</tbody>
</table>

X = X-ray required.  
R = Report required.

Note: When submitting a claim for codes D7230 and D7240, x-rays anda report are required only for patients under age 15 or over age 30.


Benefits and Limitations for Oral Surgery Services

1. Fibrocutomies are only covered on permanent first bicuspids and permanent anterior teeth.
2. Simple incision and drainage reported with root canal therapy is considered integral to the root canal therapy.
3. Extraction of erupted tooth (D7210) includes related cutting of gingival and bone, removal of tooth structure, minor smoothing of socket bone and closure.
4. Coronectomy (D7251) can be considered for benefits only when the patient is symptomatic and there is evidence that complete removal would put the inferior alveolar nerve at considerable risk of damage. Coronectomy submitted for predetermination requires pretreatment x-rays, description of the patient’s specific symptoms, and a report explaining why complete removal would put the inferior alveolar nerve at considerable risk of damage. For services not predetermined, a copy of the operative report is also required.
5. Intraoral soft-tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered integral to the procedure.
6. Biopsies are an eligible benefit when tissue is surgically removed for the specific purpose of histopathological examination and diagnosis.
7. Biopsies are considered integral when performed in conjunction with other surgical procedures on the same day in the same area of the mouth.
8. Charges for related services, such as necessary wires and splints, adjustments, and follow-up visits, are considered integral to the fee for reimplantation and/or stabilization.
9. Routine postoperative care, such as suture removal, is considered integral to the fee for the surgery.
10. Removal of impacted third molars in patients under age 15 and over age 30 is not covered unless specific documentation is provided that substantiates the need for removal and is approved by the TDP contractor.
11. Alveoloplasties performed in conjunction with extractions involving less than four teeth is not covered as a separate procedure. A network dentist cannot charge a fee to the patient.
12. Bone grafts provided for ridge preservation (D7953) (socket grafts) are covered once per tooth, per lifetime only when provided in relation to the placement of a dental implant, and will be covered at the same benefit level as dental implants. A report is required indicating the reason why the bone graft is being placed.
13. A frenulectomy (D7960) is considered integral when provided on the same day, by the same dentist, as a frenuloplasty or periodontal surgery. A frenulectomy is surgical removal or release of mucosal and muscle elements of a buccal, labial, or lingual frenum that is associated with a pathological condition, or interferes with proper oral development or treatment.
14. A frenuloplasty (D7963) is considered integral when provided on the same day, by the same dentist, as a frenulectomy or periodontal surgery.
15. Removal of residual roots (D7250) is integral when reported by the same dentist who removed the tooth.
16. Removal of a complete bony impaction with unusual surgical complications (D7241) is eligible for complicating factors such as
nerve dissection, sinus closure, or aberrant tooth position. A pretreatment x-ray and report describing the complicating factor are required for review.

**Orthodontic Services**

The TDP offers comprehensive orthodontic coverage. Please see Section 7 of this booklet for a complete description of covered benefits and how to access orthodontic care in the CONUS and OCONUS service areas.

**General Services**

To be eligible for coverage, the services listed in Figures 6.12 through 6.19 must be directly related to the covered services already listed.

**Emergency Services Codes**

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9110</td>
<td>Palliative (emergency) treatment of dental pain—minor procedure</td>
</tr>
</tbody>
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**General Anesthesia Services Codes**

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9223 R</td>
<td>Deep sedation/general anesthesia—each 15 minute increment</td>
</tr>
<tr>
<td>D9230 R</td>
<td>Inhalation of Nitrous Oxide/Analgesia, Anxiolysis (for DoD special needs beneficiaries)</td>
</tr>
</tbody>
</table>

R = Report required.
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**Intravenous Sedation Services Codes**

```
<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9243 R</td>
<td>Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment</td>
</tr>
</tbody>
</table>

R = Report required.
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**Consultation Services Codes**

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9310</td>
<td>Consultation—diagnostic service provided by dentist or physician other than requesting dentist or physician</td>
</tr>
<tr>
<td>D9311</td>
<td>Consultation with a medical health care professional</td>
</tr>
</tbody>
</table>
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**Office Visit Services Codes**

```
<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9440</td>
<td>Office visit—after regularly scheduled hours</td>
</tr>
</tbody>
</table>
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**Medication Services Codes**

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9610 R</td>
<td>Therapeutic parenteral drug—single administration</td>
</tr>
<tr>
<td>D9612 R</td>
<td>Therapeutic parenteral drugs—two or more administrations, different medications</td>
</tr>
</tbody>
</table>

R = Report required.
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**Post-Surgical Service Codes**

```
<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9930 R</td>
<td>Treatment of complications (postsurgical) unusual circumstances, by report</td>
</tr>
<tr>
<td>D9932</td>
<td>Cleaning and inspection of removable complete denture, maxillary</td>
</tr>
<tr>
<td>D9933</td>
<td>Cleaning and inspection of removable complete denture, mandibular</td>
</tr>
<tr>
<td>D9934</td>
<td>Cleaning and inspection of removable partial denture, maxillary</td>
</tr>
<tr>
<td>D9935</td>
<td>Cleaning and inspection of removable partial denture, mandibular</td>
</tr>
</tbody>
</table>

R = Report required.
```

**Miscellaneous Services Codes**

```
<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9940 R</td>
<td>Occlusal guard, by report</td>
</tr>
<tr>
<td>D9941</td>
<td>Fabrication of athletic mouth guard</td>
</tr>
<tr>
<td>D9974 X</td>
<td>Internal bleaching—per tooth</td>
</tr>
</tbody>
</table>

X = X-ray required.  R = Report required.
```


**Benefits and Limitations for General Services**

1. Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered procedure(s) and when rendered by a dentist or other professional provider licensed.
and approved to provide anesthesia in the state in which the service is rendered.

2. Deep sedation/general anesthesia and intravenous conscious sedation are covered only (by report) when determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions.

3. In order for deep sedation/general anesthesia and intravenous conscious sedation to be covered, the procedure for which it was provided must be submitted.

4. Deep sedation/general anesthesia and intravenous conscious sedation submitted without a report will be denied as a non-covered benefit.

5. Palliative (emergency) treatment is covered only if no definitive treatment is provided.

6. Palliative (emergency) treatment is a “per visit” code and is payable once per provider per date of service.

7. In order for palliative (emergency) treatment to be covered, it must involve a problem or symptom that occurred suddenly and unexpectedly that requires immediate attention, and for which the dentist must provide treatment to alleviate the enrollee’s problem. If the only service provided is to evaluate the patient and refer to another dentist and/or prescribe medication, it would be considered a Limited Oral Evaluation—Problem-Focused.

8. Consultations (D9310) provided as diagnostic services by dentists or physicians other than the requesting dentist or physician are a covered service. They are limited to one per patient per dentist per 12-month period in combination with problem-focused evaluations (D0140)—only one of these services is eligible in a 12-month period.

9. The consultation code (D9310) includes an oral evaluation. Any oral evaluation provided on the same date by the same office is considered integral to the consultation.

10. Consultations (D9310, D9311) reported for a non-covered condition, such as Temperomandibular Joint Dysfunction (TMD), are not covered.

11. After-hours visits are covered only when the dentist must return to the office after regularly scheduled hours to treat the patient in an emergency situation.

12. Therapeutic drug administrations are only payable in unusual circumstances, which must be documented by report. They are not benefits if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation, or premedication.

13. Therapeutic drug administration codes (D9610 and D9612) are not to be used to report sedatives, anesthetics, or reversal agents.

14. Therapeutic drug administration code (D9612) is not to be reported in addition to (D9610). It should be reported when two or more different drugs are administered.

15. Preparations that can be used at home, such as fluoride gels, special mouth rinses (including antimicrobials), are not covered.

16. Occlusal guards are covered by report for patients age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism (teeth grinding) or diagnoses other than TMD. Occlusal guards are limited to one per consecutive 12-month period.

17. Athletic mouth guards are limited to one per consecutive 12-month period.

18. Internal bleaching of discolored teeth (D9974) is covered by report for endodontically treated anterior teeth. A postoperative endodontic X-ray is required for consideration if the endodontic therapy has not been submitted to the TDP contractor for payment.

19. Internal bleaching of discolored teeth (D9974) is covered once per tooth per three-year period. External bleaching of discolored teeth is not covered.

20. Consultation with a medical health care professional (D9311) has a combined frequency limitation with consultations for diagnostic purposes (D9310); the combination of these procedures cannot exceed one per patient per dentist in a 12-month period.

21. Cleaning and inspection of dentures (D9932-D9935) are covered once per 12-month period. They are considered integral to a prophylaxis or evaluation provided on the same date by the same dentist.
22. Only TDP special needs beneficiaries who are identified as having the following medical conditions are eligible for nitrous oxide: Medical ICD-9 codes 317-319 (mental retardation); 330-337 (hereditary and degenerative disease of the central nervous system); 340-344 (other disorders of the central nervous system); 345 (epilepsy); and 290-299 (psychoses, including autism). The TDP contractor will pay 100 percent of its cost with no cost-share when the beneficiary is treated by a TDP network dentist. This service will not count toward the annual maximum. When a non-network provider is utilized for this service, it will still be covered at 100 percent of United Concordia’s maximum allowable charge. As with any non-network care, the beneficiary will be financially responsible for the difference between the maximum allowable charge and the provider’s charge.

**Alternative/Optional Methods of Treatment**

In instances where the dentist and the patient select a more expensive service, procedure, or course of treatment, an allowance for an alternative treatment may be paid toward the cost of the actual treatment performed. To be eligible for payment under this provision, the treatment actually performed must be consistent with sound professional standards of dental practice, and the alternative procedure for which an allowance is being paid must be a generally accepted alternative to the procedure actually performed.

In cases where alternative methods of treatment exist, payment will be allowed for the least costly, professionally accepted treatment.

The determination that an alternative treatment is an acceptable treatment is not a recommendation of which treatment should be provided. The dentist and patient should decide which treatment to select. Should the dentist and patient decide to proceed with the more expensive treatment, the patient will be financially responsible for the difference between the dentist’s fee for the more expensive treatment and the payment for the alternative service. The beneficiary has to sign a statement agreeing to pay the difference for the more expensive treatment or, if it’s not a covered procedure, the total costs. In this case, the provider will submit the signed agreement to the TDP contractor; the beneficiary will not be allowed to seek payment at a later date.

**Note:** This provision applies only when the service actually performed would be covered. If the service actually provided is not covered, then payment will not be allowed for an alternative benefit.

**Non-Covered Services**

Except as specifically provided, the following services, supplies, or charges are not covered:

1. Any dental service or treatment not specifically listed as a covered service.
2. Those 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, the TDP contractor 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.
3. Those submitted by a dentist that are for the same services performed on the same date for the same enrollee by another dentist.
4. Those that are experimental or investigative (deemed unproven).
5. Those that are for any illness or bodily injury that occurs in the course of employment if benefits or compensation is available, in whole or in part, under the provision of any legislation of any governmental unit. This exclusion applies whether or not the beneficiary claims the benefits or compensation.
6. Those that are later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law.
7. Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.
8. Those for which the patient would have no obligation to pay in the absence of this or any similar coverage. Treatment rendered by a dentist or physician who is a close relative, including spouse, children, adopted and step relatives, sisters and brothers, parents and
grandparents of the beneficiary will be declined as not a covered benefit under the TDP.

9. Those 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.

10. Those performed prior to the patient’s effective coverage date.

11. Those incurred after the termination date of the patient’s coverage, unless otherwise indicated.

12. Those that are not medically or dentally necessary or that are not recommended or approved by the treating dentist. Note: Services determined to be unnecessary or which do not meet accepted standards of dental practice are not billable to the patient by a network dentist unless the dentist notifies the patient of his or her liability prior to treatment and the patient chooses to receive the treatment. Network dentists should document such notification in their records.

13. Those not meeting accepted standards of dental practice.

14. Those that are for unusual procedures and techniques.

15. Those performed by a dentist who is compensated by a facility for similar covered services performed for beneficiaries.

16. Those resulting from the patient’s failure to comply with professionally prescribed treatment.

17. Telephone consultations.

18. Any charges for failure to keep a scheduled appointment.

19. Any services that are strictly cosmetic in nature, including, but not limited to, charges for personalization or characterization of prosthetic appliances.

20. Duplicate and temporary devices, appliances, and services.

21. Services related to the diagnosis and treatment of Temperomandibular Joint Dysfunction (TMD).

22. Plaque-control programs, oral hygiene instruction, and dietary instructions.

23. 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.

24. Restorations that are placed for cosmetic purposes only.

25. Gold foil restorations.

26. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.

27. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).

28. Adjunctive dental services as defined by applicable federal regulations.

29. Charges for copies of enrollees’ records, charts, or X-rays, or any costs associated with forwarding/mailing copies of enrollees’ records, charts, or X-rays.

30. Nitrous oxide (except for special needs enrollees with specific medical conditions).


32. State or territorial taxes on dental services performed.
Adjunctive Services

Adjunctive dental care is dental care that is:
• Medically necessary in the treatment of an otherwise-covered medical (not dental) condition
• An integral part of the treatment of such medical condition
• Essential to the control of the primary medical condition
• Required in preparation for, or as the result of, dental trauma, which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic)

The TDP does not cover services that are adjunctive dental care. Please contact your TRICARE regional contractor (medical) for coverage details. These are medical services that may be covered under TRICARE’s medical benefit, even when provided by a general dentist or oral surgeon, such as the following diagnoses or conditions:

1. Treatment for relief of myofascial pain dysfunction syndrome or TMD.
2. Orthodontic treatment for cleft lip or cleft palate, or when required in preparation for, or as a result of, trauma to teeth and supporting structures caused by medically necessary treatment of an injury or disease.
3. Procedures associated with preventive and restorative dental care when associated with radiation therapy to the head or neck, unless otherwise covered as a routine preventive procedure under this plan.
4. Total or complete ankyloglossia.
5. Intraoral abscesses that extend beyond the dental alveolus.
7. Cellulitis and osteitis that is clearly exacerbating and directly affecting a medical condition currently under treatment.
8. Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.
9. Prosthetic replacement of either the maxilla or mandible due to reduction of body tissues associated with traumatic injury (such as a gunshot wound), in addition to services related to treating neoplasms or iatrogenic dental trauma.

Dental Anesthesia Performed in a Facility Setting

Medically necessary institutional and general anesthesia services may be covered in conjunction with non-covered or non-adjunctive uniformed services dental treatment for patients with developmental, mental, or physical disabilities or for pediatric patients age 5 or younger. This general dental anesthesia benefit is covered by the TRICARE medical plan, not the TDP. Because preauthorization is required, patients should contact their TRICARE regional contractor for specific instructions. Information is available at www.tricare.mil/dental.
Orthodontic Services
The TRICARE Dental Program (TDP) covers orthodontic services. This section will highlight eligibility requirements, covered services, maximums, and how to access care.

Eligibility
Orthodontic treatment is available for family members (non-spouse) up to, but not including, age 21. If the family member is enrolled full time at an accredited college or university, he or she is eligible up to, but not including, age 23. Orthodontic treatment is also available for spouses and National Guard and Reserve sponsors up to, but not including, age 23. In all cases, coverage is effective until the end of the month in which the enrollee reaches the applicable age limit.

Note: National Guard and Reserve sponsors should check with their unit commanders to ensure compliance with service policies prior to receiving orthodontic treatment. The presence of orthodontic appliances may affect dental readiness for recall and eligibility for certain assignments and may necessitate the inactivation or removal of the orthodontic appliances at the sponsor’s expense.

Covered Services
Diagnostic Cast Services Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0470</td>
<td>Diagnostic casts</td>
</tr>
</tbody>
</table>

Note: Diagnostic casts are payable at 50 percent of the TDP contractor’s allowance, once per lifetime, when provided with covered orthodontic procedures. The limitation does not apply if the member move as a result of PCS relocation. Payment for diagnostic casts applies toward the annual maximum. For command-sponsored members in the OCONUS service area, there is no cost-share for this service.

Covered Services Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8010</td>
<td>Limited orthodontic treatment of the primary dentition</td>
</tr>
<tr>
<td>D8210</td>
<td>Removable appliance therapy</td>
</tr>
<tr>
<td>D8220</td>
<td>Fixed-appliance therapy</td>
</tr>
<tr>
<td>D8670</td>
<td>Periodic orthodontic treatment visit (as part of contract)</td>
</tr>
<tr>
<td>D8680</td>
<td>Orthodontic retention (removal of appliances, construction, and placement of retainer[s])</td>
</tr>
</tbody>
</table>
### Code Description of Service

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8690 R</td>
<td>Orthodontic treatment (alternative billing to a contract fee)</td>
</tr>
</tbody>
</table>

*R = Report required.*


### Benefits and Limitations for Orthodontic Services

1. Payment for diagnostic services performed in conjunction with orthodontics is applied to the patient’s annual maximum, except as identified in the footnote under Figure 6.1 in Section 6 of this booklet.

2. Orthodontic consultations will be processed as comprehensive or periodic evaluations and are subject to the same time limitations. See “Diagnostic Services” in Section 6 of this booklet.

3. Orthodontic treatment is available for family members (non-spouse) up to, but not including, age 21 (or up to age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50 percent of the financial support).

4. Orthodontic treatment is available for spouses and National Guard and Reserve sponsors up to, but not including, age 23. Coverage is effective until the end of the month in which the enrollee reaches the applicable age limit.

5. Initial payment for orthodontic services will not be made until a banding date has been submitted to the TDP contractor.

6. All retention and case-finishing procedures are integral to the total case fee.

7. Observations and adjustments are integral to the payment for retention appliances.

8. Repair of damaged orthodontic appliances is not covered.

9. Recementation of an orthodontic appliance by the same dentist who placed the appliance and/or who is responsible for the ongoing care of the patient is not covered. However, recementation by a different dentist will be considered for payment as palliative emergency treatment.

10. The rebonding and/or repair of a fixed retainer (D8693) is not a covered benefit.

11. The replacement of a lost or missing appliance is not a covered benefit.

12. Myofunctional therapy is integral to orthodontic treatment and is not payable as a separate benefit.

13. Orthodontic treatment (alternative billing to a contract fee) will be reviewed for individual consideration with any allowance being applied to the orthodontic lifetime maximum (OLM). It is only payable for services rendered by a dentist other than the dentist rendering complete orthodontic treatment.

14. Periodic orthodontic treatment visits (as part of contract) are considered an integral part of a complete orthodontic treatment plan and are not reimbursable as a separate service. The TDP contractor will use the corresponding appropriate code based on the treatment when making periodic payments as part of the complete treatment plan payment.

15. It is the dentist’s and the enrollees’ responsibility to notify the TDP contractor if orthodontic treatment is discontinued or completed sooner than anticipated.

### Orthodontic Lifetime Maximum

Each orthodontic payment is conditional depending on the patient’s actual remaining Orthodontic Lifetime Maximum (OLM) balance. If the patient’s OLM has been met before the payment schedule has been completed, further payments are discontinued. Payment for diagnostic services performed in conjunction with orthodontics is applied to the patient’s $1,500 annual maximum. The maximum lifetime benefit for orthodontic services under the TDP is $1,750 per enrollee.

### Orthodontic Treatment in the CONUS Service Area

#### Orthodontic Cost-Share (CONUS)

The orthodontic services listed as covered procedures are payable at 50 percent of the allowed fee or the TDP contractor’s remaining amount of the aggregate maximum benefit for
orthodontic treatment (for all dental expense periods), whichever is lower, subject to a lifetime maximum payment per enrollee of $1,750. The OLM in effect when the orthodontic treatment started will be the OLM in effect for the entire course of treatment. The patient is responsible for the 50 percent fixed cost-share until the benefit is exhausted or until the OLM is reached. When the OLM is reached, the patient is responsible for the remainder of the fee (either the TDP contractor’s allowance for a network dentist or the billed amount for a non-network dentist).

**Orthodontic Payments (CONUS)**

Orthodontic progress payments are based on the length of treatment planned by the dentist up to the $1,750 OLM. A pretreatment (predetermination) estimate prior to the start of orthodontic treatment should be submitted so the enrollee and dentist are informed of the coverage amounts and the schedule of payments. A claim should be submitted immediately following the banding date—not at the end of the orthodontic treatment. The schedule of payments is determined as follows:

- At initial banding, a payment of 25 percent of the total amount payable under the program is issued.
- The remaining 75 percent of the payable amount is paid in monthly installments, based on the estimated length of treatment, not to exceed the OLM.
- If the length of treatment is six months or less, the TDP contractor’s payment will be made in one lump sum. If the length of treatment is more than six months, but the TDP contractor’s liability is $500 or less, payment will be made in one lump sum. If the length of treatment is more than six months and more than $500, payments will be issued on a monthly basis.
- The patient must be enrolled in the TDP during each month that payment is made.
- The monthly payments are calculated and processed automatically at the end of each month.
- If an enrollee exceeds the age limitation (described earlier) during the course of orthodontic treatment, the TDP contractor’s payment will be calculated based on the months of actual eligibility. All charges incurred after the loss of eligibility will be the enrollee’s responsibility.

**Orthodontic Payment Example (CONUS)**

Orthodontists must submit an orthodontic treatment plan. This plan should include the type and length of treatment and the total charge. The TDP contractor will send notice of the treatment plan payment schedule to both the dentist and the patient. If the length of treatment is not reported, the treatment length may be determined by the TDP contractor based on the reported charge. If, during the course of treatment, there are any changes to the patient’s prescribed treatment plan that result in a change to the payment schedule, the orthodontist should notify the TDP contractor. The TDP contractor will then mail a new payment schedule to the dentist and patient.

**Payment Calculations for Eligible Treatment (CONUS)**

The following example is intended only to show how payments are calculated; actual fees, duration of treatment, and payments will vary.

**Example:** A TDP network dentist (orthodontist) charges an allowed fee of $4,000. The length of treatment is 24 months and no previous OLM was used. The orthodontic payment would be calculated as follows:

<table>
<thead>
<tr>
<th>United Concordia payment = $1,750</th>
<th>$4,000 x 50% cost-share = $2,000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong> The enrollee has to pay the amount left unpaid by the TDP after applying the OLM. In this example, this is calculated as: $2,000 insurance cost-share - $1,750 OLM = $250</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Beneficiary out-of-pocket cost = $2,250</th>
<th>$4,000 x 50% cost-share = $2,000 + $250</th>
</tr>
</thead>
<tbody>
<tr>
<td>(amount remaining after application of OLM)</td>
<td></td>
</tr>
</tbody>
</table>

| United Concordia’s installments to the dentist would be made as follows: |
| TDP contractor payment at initial banding | $1,750 x 25% = $437.50 |
| 24 monthly payments of $54.69 each | $1,312.50 ÷ 24 = $54.69 |
| **Note:** The TDP contractor still owes the amount of the OLM remaining after the initial payment, $1,750 - $437.50 = $1,312.50. |
Orthodontic Treatment in the OCONUS Service Area

Please be aware that in OCONUS locations, sponsors and family members may be asked by a dentist to pay for covered services before services are rendered. If an enrollee is receiving care from a TRICARE OCONUS Preferred Dentist (TOPD), that payment should be limited to the enrollee’s cost-share.

OCONUS Orthodontic Services

For orthodontic services, beneficiaries in all OCONUS locations are required to have a Non-Availability and Referral Form (NARF) issued by the TRICARE Area Office (TAO) or designated OCONUS points of contact (POCs). Any licensed orthodontist can provide orthodontic care, although TOPD orthodontists will only collect enrollee cost shares up front. For your convenience, the TDP maintains a TOPD list that can be accessed at www.uccitdp.com.

Orthodontic Cost-Share (OCONUS)

For orthodontic services received by command-sponsored enrollees, claims are paid as follows:

- Enrollee pays cost-share based on the lesser of dentist’s actual charge or the TDP contractor’s allowed fee.
- The TDP contractor pays the remaining appropriate billed charges, but for command-sponsored enrollees, the TDP contractor is reimbursed by the government for billed charges in excess of the allowed fee.

Although OCONUS coverage is available for enrolled Selected Reserve and Individual Ready Reserve (IRR) family members and IRR (other than special mobilization category) members, such enrollees’ claims (as well as any other enrollee who is not command-sponsored) are administered based upon the CONUS guidelines for out-of-network care. The $1,750 OLM applies, the CONUS cost-shares apply, and the enrollee is responsible for the dentist’s or orthodontist’s fee in excess of the TDP contractor’s allowed fee.

Orthodontic Payments (OCONUS)

Payment for orthodontic treatment initiated in the OCONUS service area for command-sponsored enrollees will be issued in one lump sum, subject to approval of the OCONUS orthodontist’s treatment plan. The TDP contractor will make one payment that includes the portion of the claim reimbursed by the government for command-sponsored beneficiaries. The remaining liability is the responsibility of the beneficiary. That liability for a command-sponsored beneficiary should be limited to the 50 percent cost-share of the allowed fee.

If an enrollee exceeds the age limitation (described earlier) during the course of orthodontic treatment, the TDP contractor’s payment will be calculated based on the months of actual eligibility. All charges incurred after the loss of eligibility will be the enrollee’s responsibility.

Sponsors and family members contemplating orthodontic care in the OCONUS service area are cautioned that, because OCONUS dentists are paid a lump sum, their $1,750 OLM may be fully exhausted when they return to the CONUS service area, regardless of whether or not the orthodontic care was completed.

When using a TOPD, please note that the TDP contractor pays the orthodontist directly for services. Also, please only pay the applicable cost-share.

Orthodontic Payment Example (command-sponsored beneficiary in OCONUS location)

Example: The total fee charged by a dentist (orthodontist) is $5,000 and the TDP contractor allowed fee is $4,000:

| TDP contractor payment = $3,000 | $4,000 x 50% cost-share = $2,000 |
| $2,000 insurance cost-share + $1,000 | (amount of dentist actual fee in excess of allowed fee) |
| Note: In OCONUS locations, the government reimburses the TDP contractor for the portion of charges that exceeds the OLM for command-sponsored members. In this example, this is $2,000 - $1,750 = $250. |

| Beneficiary out-of-pocket cost = $2,000 | $4,000 x 50% = $2,000 |

1. The TDP contractor will pay the dentist directly in one lump sum. That portion of the payment that relates to charges in excess of the allowed fee and orthodontia lifetime maximum is paid by the TDP contractor which, in turn, is reimbursed by the government.
**OCONUS Locations**

Before any orthodontic care, the TAO or designated OCONUS POCs must issue an initial NARF for an orthodontic examination and treatment plan authorizing the beneficiary to seek orthodontic care from an OCONUS orthodontist. Please reference the TOPD list that includes orthodontists for availability in your area. A listing of the TOPDs is maintained for your convenience and can be found online at [www.uccitdp.com](http://www.uccitdp.com). However, you are free to seek care from any licensed and authorized dentist (orthodontist).

After the initial exam is completed, the initial NARF, the claim form, and the provider’s bill for the initial exam and treatment plan should be sent to the TDP contractor for payment.

If an estimate is submitted with all the necessary information along with an approved NARF, when the actual treatment is rendered, the TDP contractor does not require submission of a second NARF. The only time the TDP contractor requires a second NARF is when the provider only sends the exam/workup for orthodontics without reference to future treatments. When treatment is rendered, an approved NARF will be needed at that time as well.

**Note:** Patients are recommended to seek a predetermination of payment from the TDP contractor for all orthodontic and complex dental treatment plans. To submit the predetermination request, complete a claim form and include a statement from the orthodontist identifying the total cost of all treatment needed. The TDP contractor will review and provide the patient with a summary of the covered costs. Patients have a $1,750 OLM benefit.

After receiving the predetermination, the sponsor may submit the second NARF (approving the comprehensive orthodontic treatment), the claim form, and the dentist’s bill for full orthodontic treatment to the TDP contractor for payment. TDP claim forms are available at [www.uccitdp.com](http://www.uccitdp.com). TRICARE Dental Program (TDP) predeterminations are valid for six months from the date of finalization.

**Transferring Orthodontists**

**CONUS to CONUS**

If the patient transfers to a different orthodontist, the new orthodontist must submit a claim to the TDP contractor. Payments for the new orthodontist’s services will be calculated based on the remaining OLM. It is the orthodontist’s and patient’s responsibility to notify United Concordia if orthodontic treatment is discontinued or completed sooner than anticipated.

**CONUS to OCONUS**

Orthodontic care initiated in the CONUS service area may be continued OCONUS as long as the OLM has not been met. All beneficiaries must obtain a NARF from their TAO (or designee) before transferring to an OCONUS orthodontist. Upon issuance of the NARF and approval of the OCONUS orthodontist’s treatment plan, a lump-sum payment will be issued based on the patient’s remaining OLM.

**OCONUS to CONUS**

Orthodontic care that was provided OCONUS will typically be paid in a lump sum. If total payments made by the TDP met or exceeded the OLM, that enrollee will be ineligible for additional claim payments by the TDP for services subsequently received in CONUS locations.
TRICARE Dental Program Claim Filing

This section explains predeterminations and the claim-filing process for the CONUS and OCONUS service areas. All premium payments must be current for claims to be paid. If the premiums are not current, it will result in the delay or denial of the claim.

Predetermination Requests

The TDP contractor encourages the use of predeterminations for treatment plans involving onlays, crowns, implants, prosthodontics, periodontics, orthodontics, and oral surgery services. This allows the dentist and the beneficiary to know, prior to receiving treatment, if the proposed service(s) will be covered by the TDP contractor and the anticipated amount of payment.

To request predetermination, the dentist or beneficiary must submit a dental claim form and indicate on the form that a predetermination is being requested. Once the predetermination is finalized, the TDP contractor will notify both the enrollee and the dentist through a Dental Estimate of Benefit Notification. A predetermination is not a guarantee of payment or benefit coverage, but indicates how much would be payable given the information available at the time the determination is processed.

When the predetermined service has been provided, the dentist or beneficiary must return the Dental Estimate of Benefit Notification to the TDP contractor indicating the date the service was provided. If multiple services have been predetermined, it is not necessary to have all services performed in order for the predetermination notification to be returned for processing.

TRICARE Dental Program (TDP) predeterminations are valid for six months from the date of finalization. The Dental Estimate of Benefit Notification contains the date that the predetermination was approved. If the reported service is performed after the predetermination approval has expired, the service will be reviewed to determine if it is still eligible for payment.

CONUS Claims

The TDP contractor will accept claims filed on any standard dental claim form of the American Dental Association®. The TDP contractor claim forms include instructions and are available at www.uccitdp.com. A separate claim form must be submitted for each beneficiary receiving services.

Submitting Claims

Beneficiaries may go to any authorized or licensed dentist of their choice. If the dentist is a TDP network dentist, his or her office will handle all paperwork, including filing claims. If the dentist does not participate in the TDP network, beneficiaries may need to file their own claims.

Please include the sponsor’s Social Security number (SSN) or individual’s Department of Defense (DoD) Benefits Number (DBN) with any supporting documents submitted to the TDP contractor regarding a claim.

Claim-Filing Deadline

All claim forms should be submitted to the TDP contractor as soon as possible after the date of service. Claims submitted more than 12 months after services were performed will be denied. A TDP network dentist may not bill the patient for services that are
denied for this reason. Prompt submission is especially important for claims involving an orthodontic treatment plan, as the banding date is used to determine the start of orthodontic treatment.

Claim Payments

If an enrollee receives care from a TDP network dentist, the TDP contractor will pay the dentist directly for covered services, less any cost-shares. The dentist will typically bill the beneficiary directly for his or her cost-share. When a non-network dentist performs services, the TDP contractor will pay for covered services up to the TDP contractor’s allowance,* less any cost-shares. The beneficiary is responsible for making payment for his or her cost-share and any part of the dentist’s fee exceeding the TDP contractor’s allowance. The TDP contractor will pay a non-network dentist directly only if the beneficiary designates on the claim form that the dentist is to receive the payment. This is sometimes referred to as assignment of benefit.

Note: Seeking care from a TDP network dentist will often reduce the beneficiary’s out-of-pocket costs.

* If the beneficiary chooses to not sign an assignment of benefits statement on the claim form, the provider may request reimbursement from the beneficiary up to the TDP network fee at time of treatment. In this case the TDP contractor will issue any applicable reimbursement directly to the beneficiary.

OCONUS Claims

The quickest and easiest way to get a claim form is online. If online access is not convenient for you, claim forms are also available from the nearest TRICARE Area Office (TAO), overseas uniformed services dental treatment facility (ODTF), designated OCONUS points of contact (POCs). Please reference the inside front cover of this booklet for contact information.

Submitting Claims

For dental care provided in OCONUS locations, if the claim form does not already provide the following information, please be sure to include:

- Date(s) of service
- Provider name, address, and phone number
- Specific problem encountered
- Procedure code(s)
- Specific tooth/teeth treated for each service performed, where appropriate
- Total charges
- If a procedure code is not provided on the claim form, a complete description of the service performed, including applicable tooth number(s) should be provided, where appropriate

For the TDP contractor to process claims, the following is needed:

- A completed claim form
- A dentist bill or statement of charges. If the specific service(s) provided is repeated on the claim form, a separate office bill is not needed
- Non-Availability and Referral Form (NARF) for orthodontia

Claim-Filing Deadline

The claim form must be completed and submitted to the TDP contractor as soon as possible following the date of service. If the claim is submitted to the TDP contractor more than 12 months after the service was performed, the claim will be denied.

OCONUS Claim Payments

Within OCONUS locations, some dentists may require beneficiaries to pay for services before they are rendered.

Orthodontia claims in OCONUS locations will typically be paid directly to the dentist. For services other than orthodontia, the TDP contractor will make payment for covered services to either the dentist or enrollee, depending on which party submitted the claim. In cases in which the dentist submitted the claim, the TDP contractor will issue payment to the dentist and a dental explanation of benefits (DEOB) to both the dentist and the beneficiary. In cases in which the beneficiary forwarded the claim, the TDP contractor will issue payment and a DEOB to the beneficiary. If the beneficiary submits the claim and states that payment should be made directly to the dentist, the beneficiary must sign the portion of the claim form that assigns payment to the dentist. If the TDP contractor is
unable to determine which party forwarded the claim, payment will be issued to the dentist.

All payments issued to a dentist from the OCONUS service area will be paid in foreign currency, subject to the availability of these currencies through recognized U.S. banking institutions. All claims submitted by beneficiaries will be paid in U.S. dollars.

After a foreign draft (in foreign currency) has been issued, payment will not be changed to U.S. dollars. All payments requiring conversion to foreign currency will be calculated based on the exchange rate in effect on the last date of service listed on the claim or bill.

**OCONUS Point-of-Contact Program**

For assistance with general questions about OCONUS or submitting OCONUS claims, please reference the inside front cover of this booklet for contact information and details.

**Note:** For orthodontia, contact the TAO dental POC for the completion of the NARF prior to orthodontia treatment.

**Dental Explanation of Benefits**

A DEOB is a statement provided to the enrollee or dentist explaining what services were covered and the amount of coverage. This will allow the beneficiary to determine his or her expected cost-share, if any. If there is a cost-share, the beneficiary must pay the dentist that amount, plus any costs for non-covered services or the dentist’s fee in excess of the allowed charge. Dentists will receive a DEOB if benefits were assigned and payment is being issued directly to the dentist. See the following pages for information regarding the DEOB.

**Understanding Your DEOB**

The information described in Figure 8.1 will appear at the top of the DEOB.

### Understanding the Dental Explanation of Benefits

<table>
<thead>
<tr>
<th>Data field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsor’s name</td>
<td>Name of the uniformed service member</td>
</tr>
<tr>
<td>DBN</td>
<td>Beneficiary’s Department of Defense Benefits Number</td>
</tr>
<tr>
<td>Beneficiary name</td>
<td>Name of the beneficiary who received the services – must match what’s in DEERS</td>
</tr>
<tr>
<td>Internal Control Number (ICN)</td>
<td>The unique number that identifies the image of the claim received. Reference this number for questions about the DEOB.</td>
</tr>
<tr>
<td>Date processed</td>
<td>Date the dental explanation of benefits (DEOB) was issued</td>
</tr>
<tr>
<td>Provider</td>
<td>Name of dentist who provided the service or treatment</td>
</tr>
<tr>
<td>Procedure description/ Procedure code</td>
<td>Procedure code identifying the service performed (D + a four digit number). Includes tooth number/ range if applicable.</td>
</tr>
<tr>
<td>Service date</td>
<td>Date the beneficiary received treatment</td>
</tr>
<tr>
<td>Provider’s charge</td>
<td>Amount charged by the dentist</td>
</tr>
<tr>
<td>Allowance</td>
<td>Amount the TDP contractor considers for the service. It includes adjustments for limitations and exclusions.</td>
</tr>
<tr>
<td>Amount paid</td>
<td>Amount the TDP contractor will pay for the treatment. It includes adjustments for cost-shares and maximums.</td>
</tr>
<tr>
<td>Amount not paid</td>
<td>Amount not covered by the plan</td>
</tr>
<tr>
<td>Remarks</td>
<td>Special messages and/or message references explaining claim payments</td>
</tr>
</tbody>
</table>

Beneficiaries may elect to view their DEOBs electronically by visiting [www.uccitdp.com](http://www.uccitdp.com).

**Note:** DEOBs issued for treatment received in the OCONUS service area may include additional information not indicated on CONUS DEOBs (for example, foreign exchange rate). Beneficiaries should direct inquiries to the TDP contractor’s OCONUS customer service unit.
Questions about the DEOB

For questions about DEOBs, please reference the inside front cover of this booklet for contact information. Be sure to have the following information available when calling:

- Your name and date of birth
- Patient’s DBN and/or sponsor’s SSN
- Beneficiary/patient name
- Internal control number (ICN) of claim from the DEOB

Other Dental Insurance—Coordinating Benefits with the TDP

A TDP beneficiary may have other dental insurance. In this case, the TDP contractor will coordinate benefits between the two dental plans.

If a beneficiary receives services that are covered under the TDP and another dental plan, coverage and benefits are governed by coordination of benefits rules. These rules determine which plan pays benefits first and which plan pays benefits second.

Depending on the situation, the TDP may be the primary or secondary dental plan:

- Whenever a spouse’s or child’s other plan is primarily a medical insurance plan, but includes a dental benefit, the plan is considered secondary. The TDP is considered primary and claims should be submitted to the TDP contractor.
- When a spouse has his or her own dental plan, the spouse’s dental plan is considered primary and the TDP is secondary.
- In the case of a child who is covered under two dental plans, the primary plan is typically determined by the “birthday rule,” which has been established by the National Association of Insurance Commissioners. The birthday rule determines the first plan to pay benefits based on which parent’s birthday falls earlier in a calendar year. For example: If the mother’s birthday is January 2 and the father’s birthday is January 12, the mother’s dental plan is considered primary and would pay benefits first.
- An exception to the birthday rule occurs if the other dental plan uses the “gender rule.” The gender rule specifies that the male parent’s dental plan is considered the primary plan.

In determining coordination of benefits, the TDP contractor will defer to the gender rule and consider the male parent’s dental plan as the primary plan.

- In situations where the natural parents are not married and there are two dental plans, the TDP contractor considers the insurance plan of the parent with custody to be the primary plan. If the parent with custody has remarried, the stepparent’s plan will pay before the plan of the parent without custody. An exception to this rule occurs when there is a court decree specifying which parent is responsible for insurance coverage.

Claims should always be filed with the primary plan first. After payment has been received from the primary plan, the claim can be filed with the secondary plan. When submitting a claim to the TDP contractor for coordination under the TDP as secondary coverage, a copy of the primary insurance plan’s DEOB must be attached.

The primary plan pays benefits without regard to the secondary plan. When TDP coverage is secondary, the plan pays for covered services that have not been paid by the primary plan. The TDP will coordinate with the primary insurance carrier and pay for TDP-covered services according to TDP provisions and limitations. Payment as the secondary carrier will not exceed the provider charge or the amount the TDP would have paid as the primary carrier, whichever is less. In no instances should the total payments for a service by the primary and secondary carrier exceed the dentist’s charge.

Coordination of Benefits Scenarios

Figures 8.2, 8.3, and 8.4 show examples of the coordination of benefits between primary and secondary dental carriers for sample procedures.
### Coordination of Benefits Scenario 1

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Procedure</th>
<th>Dentist’s Charge</th>
<th>Covered Expense</th>
<th>Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Exam</td>
<td>$35</td>
<td>$28</td>
<td>$28</td>
</tr>
<tr>
<td>TRICARE Dental Program (secondary)</td>
<td>Exam</td>
<td>$35</td>
<td>$30</td>
<td>$7</td>
</tr>
</tbody>
</table>

As shown in Figure 8.2, the primary carrier paid $28 for a $35 exam. The remaining balance of $7 ($35 - $28 = $7) is less than the TDP contractor’s allowance of $30, so the TDP contractor will pay $7 (up to the $35 billed charge).

### Coordination of Benefits Scenario 2

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Procedure</th>
<th>Dentist’s Charge</th>
<th>Covered Expense</th>
<th>Cost-share Amount</th>
<th>Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Restoration</td>
<td>$95</td>
<td>$80 (patient responsible for 20% cost-share)</td>
<td>80%</td>
<td>$64</td>
</tr>
<tr>
<td>TRICARE Dental Program (secondary)</td>
<td>Restoration</td>
<td>$95</td>
<td>$70 (patient responsible for 20% cost-share)</td>
<td>80%</td>
<td>$31</td>
</tr>
</tbody>
</table>

As shown in Figure 8.3, the primary carrier paid $64 ($80 x 80% = $64) for a $95 restoration. Under the TDP, restorations have a 20 percent beneficiary cost-share. Had TDP been primary, $56 would have been paid for this restoration ($70 x 80% = $56). This means the beneficiary would owe $16 ($80 x 20% = $16). However, since the remaining balance of $31 ($95 - $64 = $31) is less than $56, the TDP contractor pays the full $31 as the secondary payer. You have no out-of-pocket costs.

### Coordination of Benefits Scenario 3

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Procedure</th>
<th>Dentist’s Charge</th>
<th>Covered Expense</th>
<th>Cost-share Amount</th>
<th>Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Crown</td>
<td>$800</td>
<td>$700</td>
<td>50%</td>
<td>$350</td>
</tr>
<tr>
<td>TRICARE Dental Program (secondary)</td>
<td>Crown</td>
<td>$800</td>
<td>$650</td>
<td>50%</td>
<td>$325</td>
</tr>
</tbody>
</table>

As shown in Figure 8.4, the primary carrier paid $350 for an $800 crown. The remaining balance is $450 ($800 - $350 = $450). If the TDP coverage had been primary, the TDP contractor would have paid 50 percent of $650 (the TDP contractor’s allowance), which is $325. Since the remaining balance of $450 ($800 - $350 = $450) is greater than $325, the TDP contractor would only pay an additional $325 toward the $800 billed charge. The TDP enrollee’s out-of-pocket cost is $125 ($450 - $325 = $125).
Traveling and Moving with the TRICARE Dental Program

Your dental coverage is worldwide, whether you are traveling on leave or moving to a new duty location.

**Traveling**

**CONUS to CONUS**

When traveling anywhere in the CONUS service area, you are welcome to visit any licensed dentist. However, visiting a TDP network dentist may save you time and money. To find a TDP network dentist, please visit [www.uccitdp.com](http://www.uccitdp.com).

*Note:* You can search for a dentist by specialty, last name, city, or ZIP code, and the online directory is updated weekly.

**CONUS to OCONUS**

TRICARE Dental Program (TDP)-enrolled beneficiaries who reside in the CONUS service area are also covered in the OCONUS service area. Those enrolled in the CONUS service area that visit OCONUS countries will be subject to CONUS cost-shares and will essentially have claims paid as if visiting an out-of-network dentist.

**OCONUS to CONUS**

TDP-enrolled beneficiaries who reside in the OCONUS service area are also covered in the CONUS service area. Enrollees residing in the OCONUS service area, but who receive dental care in a CONUS location, are subject to the CONUS cost-shares and payment rules, regardless of command sponsorship status.

**OCONUS to OCONUS**

TDP enrollees who reside in the OCONUS service area are covered while traveling or moving to a new OCONUS service area. Enrollees who seek service in the OCONUS service area and are command-sponsored will have reduced cost-shares and claim payment rules that are noted in Section 5 and Section 7 of this booklet.

**Moving**

The TDP makes moving easy—there’s no need to fill out new enrollment applications when you move. Coverage stays in place when you move.

*Note:* The TDP does not cover duplication of records for a sponsor’s permanent change of station; therefore, beneficiaries are encouraged to obtain copies of their dental records before moving, to avoid the possibility of incurring additional expenses at their new location.

To update your address, please visit [www.dmdc.osd.mil/appj/address/index.jsp](http://www.dmdc.osd.mil/appj/address/index.jsp). Also, please visit [www.uccitdp.com](http://www.uccitdp.com) to locate a TDP network dentist.

Enrolled beneficiaries who relocate to locations within the OCONUS service area may choose, within 90 calendar days of the relocation, to terminate enrollment from the TDP.
If you are unable to resolve an issue satisfactorily through the TDP contractor customer service channels or your dentist, there are appeal and grievance options available to you. This section also includes procedures for reporting suspected fraud or abuse.

**TRICARE Dental Program Appeals Process**

If a patient or network dentist disagrees with the TDP contractor’s benefit decision, that decision may be eligible for an appeal. The appeals process provides an opportunity for parties to appeal adverse benefit decisions relating to the initial determination.

**Who Can Request an Appeal?**

Parties to the initial determination can request an appeal including:

- Network dentists
- The patient who received dental services
- Sponsors, parents, or guardians of beneficiaries who are under age 18 or mentally incompetent
- An individual or non-network dentist who has been appointed, in writing, by the patient to act as the patient’s representative in the appeal

The Appointment of Individual to Act as Appeal Representative Form can be submitted online or downloaded from the “Forms and Materials” section at [www.uccitdp.com](http://www.uccitdp.com).

**Who Cannot Request an Appeal?**

The following cannot request an appeal:

- Dentists who are disqualified or excluded from being authorized dentists
- Non-network dentists (unless appointed in writing by an appealable party to act on their behalf)
- Beneficiaries who have an interest in receiving care or who have received care from a particular dentist who has been excluded, suspended, or terminated as an authorized dentist
- Sponsors, parents, or guardians of family members age 18 and older are not parties to the initial determination. However, they may represent the family member if the family member appoints them in writing
- Third parties such as other insurance companies

**What Can and Cannot Be Appealed?**

To appeal a claim, there must be a dollar amount in dispute for which the patient has financial responsibility. The amount in dispute is calculated as the actual amount that would be payable under the TRICARE Dental Program (TDP) if the services involved in the dispute were determined to be payable, minus any applicable cost-share or other dental insurance payment. Adverse decisions on predetermination requests may also be appealed.

The following issues cannot be appealed:

- Disputes regarding requirement of law or regulation
- The amount the TDP contractor determines to be the allowable charge
- Plan eligibility rules
- Dentists who have been excluded or suspended by a government agency or state or local licensing authority
- Amounts exceeding the patient’s plan year or lifetime maximum
- Services that are denied due to timely filing limitation

**Appeal Levels**

There are three levels of appeal: reconsideration, formal review, and hearing.

**Level I: Reconsideration**

Reconsideration is a formal request made by beneficiaries and dentists to the TDP contractor to seek a separate review from the initial payment determination to assess whether the initial payment decision was correct.
**How to Request a Reconsideration**

The request must be in writing and include all rationale (reason for the request), supporting documentation (for example, X-rays; dated periodontal charting; clinical narratives; permanent change of station orders, if applicable; progress notes; treatment records), and a copy of the initial determination. The reconsideration request can be submitted online at [www.uccitdp.com](http://www.uccitdp.com) or mailed to the TDP contractor. The reconsideration request must be postmarked or received by the TDP contractor within 90 calendar days of the issue date of the dental explanation of benefits (DEOB). The issue date (claim year and month) is located on the upper right corner of the DEOB. Because the request for reconsideration must be filed within 90 days, the appeal request should not be delayed to obtain supporting records if the records are not readily available. If supporting records will be submitted at a later date, the appeal letter should contain the expected date of submission.

**Note:** These instructions, as well as the patient’s right to appeal, are also provided on the DEOB. Requests for reconsideration must be submitted separately from dental claim forms. If submitted together in the same envelope, the reconsideration will be processed as a claim and denied as a duplicate.

**What Happens During a Reconsideration?**

The TDP contractor will review all documentation submitted and conduct a thorough investigation. The TDP contractor may contact the enrollee or the dentist for additional information and, in some cases, refer the claim to a TDP contractor dentist consultant.

The reconsideration may result in full or partial approval of the disputed costs or confirmation of the initial decision. Written notification of the reconsideration decision and the action taken, if any, should be issued within 60 days of the receipt date of the appeal request. The patient will be sent a copy of the reconsideration decision no matter who requested the reconsideration. The TDP network dentist (or non-network dentist who has been appointed as representative or who has benefits assigned to him or her) will also be notified.

Reconsideration requests must be submitted in writing to:

**CONUS/OCONUS:**
United Concordia
TRICARE Dental Program
P.O. Box 69451
Harrisburg, PA 17106

Fax: 1-717-635-4565 (CONUS) or 1-844-827-9926 (OCONUS toll-free) or 1-717-635-4520 (OCONUS toll)

**Level II: Formal Review**

Patients may request a formal review from the Defense Health Agency (DHA) if they disagree with the TDP contractor’s reconsideration and if the amount remaining in dispute is $50 or more. The letter containing notification of the TDP contractor’s reconsideration decision will include a notice of the patient’s right to a formal review and instructions on how to request one.

**How to Request a Formal Review**

A request for a formal review must be postmarked or received by DHA within 60 days from the date of the reconsideration determination. The request must be in writing and include copies of the reconsideration determination and any other information not supplied with the original appeal request. Because the request for formal review must be filed within 60 days, the appeal request should not be delayed to obtain supporting records if the records are not readily available. If supporting records will be submitted at a later date, the appeal letter should contain the expected date of submission.

The request for formal review should be sent to:

Defense Health Agency
Appeals, Hearings, and Claims
Collection Division
16401 E. Centretech Parkway
Aurora, CO 80011-9066

**Level III: Hearing**

If a patient disagrees with the formal review decision from DHA and the amount in dispute is $300 or more, he or she may request a hearing with DHA. The request must be in writing and include copies of the formal review decision.
and any other information not supplied with the previous appeal requests. The request must be postmarked or received by DHA within 60 days of the date of the formal review decision (the date on the letter from DHA providing the results of the formal review). Because the request for a hearing must be filed within 60 days, the appeal request should not be delayed to obtain supporting records if the records are not readily available. If supporting records will be submitted at a later date, the appeal letter should contain the expected date of submission.

The request for a hearing should be sent to:

Defense Health Agency
Appeals, Hearings, and Claims
Collection Division
16401 E. Centretech Parkway
Aurora, CO 80011-9066

Grievances

Continuous quality-assurance review procedures are employed to ensure that patients receive necessary quality care and that services are billed properly. The TDP contractor only pays benefits for dental services that meet acceptable standards of dental practice. In rare cases, a dentist may be removed from the listing of participating dentists if the TDP contractor determines that he or she is not providing care within acceptable standards of dental practice.

Questions concerning the quality of care received should first be discussed with the dentist that provided the services. Concerns can often be handled by asking the dentist questions about the uniformed services dental treatment. If there are still concerns after talking to the dentist, submit them via www.ucitdp.com in the “Forms and Materials” section or in writing to the TDP contractor at:

United Concordia - TDP Grievances
1800 Center Street, 2AL4
Camp Hill, PA 17089

Fax: 1-717-260-7168

Letters should include the sponsor’s name and Social Security number or the patient’s Department of Defense Benefits Number, the patient’s name and relationship to the sponsor, the dentist’s name and address, and an explanation of the concern. The TDP contractor will investigate the concern, resolve it as appropriate, and notify the requestor of the results.

The quality of OCONUS dentists is not controlled by the government or the TDP contractor or any of its agents or representatives. The government’s control over foreign dentists is limited to their inclusion in or exclusion from the TRICARE OCONUS Preferred Dentist lists. Sponsors or family members should forward any complaints or concerns about overseas dental service or quality of care to the TDP contractor at the address listed earlier. Grievances received by the overseas uniformed services dental treatment facility or TRICARE Area Office or designated OCONUS points of contact, should be forwarded to the TDP contractor for action.

Fraud and Abuse

Fraud and abuse can take many forms. Examples of fraudulent and/or abusive practices include, but are not limited to:

• Submitting claims for services not rendered
• Submitting claims for non-covered services disguised as covered benefit services
• Identity thefts—submitting claims for a non-eligible individual as a covered beneficiary
• Duplicate claims submissions
• Dentist misrepresents his or her credentials or conceals information regarding business practices that disqualifies him or her as an authorized TDP provider
• Improper billing practices, submitting claims for unnecessary dental services
• Routine waiver of beneficiary cost-share

TRICARE sponsors and beneficiaries have the ability and opportunity to detect fraud. The key is careful review of the DEOB. Make sure that the information on the DEOB matches the services you received.

For example:

• Verify the date of service
• Verify the type of services rendered
• Verify the payment issued was for the actual rendered services
United Concordia, as a federal contractor, is forbidden to pay claims for services rendered by those dentists or entities that have been sanctioned by the U.S. Department of Health and Human Services, Office of Inspector General. Reasons for the sanctions include convictions for program-related fraud, patient abuse, and licensing-board actions. The director of DHA (or designee) also has sanction authority. In either case, the dentist or entity that has been sanctioned has forfeited his or her entitlement to bill the TDP contractor or the beneficiary for the rendered services. The TDP contractor will deny the services and issue a DEOB message that states that the dentist or entity may not bill anyone for the denied services.

On a monthly basis, the government notifies the TDP contractor of dentists or entities that have been sanctioned. The government also includes a list of individuals who have been reinstated. The list of sanctioned dentists can be found at http://oig.hhs.gov.

**Reporting Fraud and Abuse**

If a beneficiary believes a dentist or entity received insurance money through the submission of a false claim, he or she should report this information to the Special Investigations Unit (SIU). The TDP contractor provides several ways for beneficiaries to contact the SIU:

- Submit written correspondence directly to:
  
  United Concordia  
  Special Investigations Unit—TDP  
  4401 Deer Path Road  
  DP3B  
  Harrisburg, PA 17110

- Call the toll-free “Fraud Hotline” at 1-877-968-7455

The SIU maintains a 24-hour confidential voice mailbox for reporting suspected fraud.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA</td>
<td>American Dental Association</td>
</tr>
<tr>
<td>ADFM</td>
<td>Active duty family member</td>
</tr>
<tr>
<td>ADSM</td>
<td>Active duty service member</td>
</tr>
<tr>
<td>BCAC</td>
<td>Beneficiary Counseling and Assistance Coordinator</td>
</tr>
<tr>
<td>CONUS</td>
<td>The TDP CONUS service area includes the 50 United States, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands.</td>
</tr>
<tr>
<td>BWE</td>
<td>Beneficiary Web Enrollment</td>
</tr>
<tr>
<td>DBN</td>
<td>Department of Defense Benefits Number</td>
</tr>
<tr>
<td>DCAO</td>
<td>Debt Collection Assistance Officer</td>
</tr>
<tr>
<td>DCN</td>
<td>Document control number</td>
</tr>
<tr>
<td>DEERS</td>
<td>Defense Enrollment Eligibility Reporting System</td>
</tr>
<tr>
<td>DEOB</td>
<td>Dental explanation of benefits</td>
</tr>
<tr>
<td>DHA</td>
<td>Defense Health Agency</td>
</tr>
<tr>
<td>DoD</td>
<td>Department of Defense</td>
</tr>
<tr>
<td>DTF</td>
<td>Dental treatment facility</td>
</tr>
<tr>
<td>FPD</td>
<td>Full partial denture</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>ID</td>
<td>Identification</td>
</tr>
<tr>
<td>IRR</td>
<td>Individual Ready Reserve</td>
</tr>
<tr>
<td>MTF</td>
<td>Military treatment facility</td>
</tr>
<tr>
<td>NARF</td>
<td>Non-Availability and Referral Form</td>
</tr>
<tr>
<td>OCONUS</td>
<td>Outside the Continental United States. Includes all areas outside the CONUS service area. This includes covered services provided on a ship or vessel outside the territorial waters of the CONUS service area.</td>
</tr>
<tr>
<td>ODTF</td>
<td>Overseas dental treatment facility</td>
</tr>
<tr>
<td>OLM</td>
<td>Orthodontic lifetime maximum</td>
</tr>
<tr>
<td>PCS</td>
<td>Permanent change of station</td>
</tr>
<tr>
<td>POA</td>
<td>Power of attorney</td>
</tr>
<tr>
<td>SIU</td>
<td>Special Investigations Unit</td>
</tr>
<tr>
<td>SSN</td>
<td>Social Security number</td>
</tr>
<tr>
<td>TAMP</td>
<td>Transitional Assistance Management Program</td>
</tr>
<tr>
<td>TAO</td>
<td>TRICARE Area Office</td>
</tr>
<tr>
<td>TDP</td>
<td>TRICARE Dental Program</td>
</tr>
<tr>
<td>TMD</td>
<td>Temporomandibular joint dysfunction</td>
</tr>
<tr>
<td>TOPD</td>
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**Glossary of Terms**

**Adjunctive Dental Care**
Dental care that is medically necessary in the treatment of an otherwise covered medical (not dental) condition; is an integral part of the treatment of the medical condition; or is required in preparation for, or as a result of, dental trauma; or is caused by medically necessary treatment of an injury or disease. These services are considered medical, not dental, and they may be covered under the TRICARE medical benefit as adjunctive dental services.

**Allowable Charge/Allowance/Allowed Fee**
The fee charged by a dentist that the TDP contractor will consider for payment. For a TDP network dentist, it is the dentist’s normal charge, or negotiated fee, whichever is lower. For non-network dentists, it is their fee, subject to caps, to reflect the range of reasonable and customary charges by dentists in the area. As always, final payment to the beneficiary or dentist may be impacted by TDP limitations and exclusions.

**Amalgam**
An alloy used in direct dental restorations. Typically composed of mercury, silver, tin, and copper along with other metallic elements added to improve physical and mechanical properties.

**American Dental Association (ADA)**
The ADA is the professional association of dentists committed to the public’s oral health, ethics, science, and professional advancement; leading a unified profession through initiatives in advocacy, education, research, and the development of standards.

**Appeals/Reconsiderations**
Procedures provided for beneficiaries and dentists who disagree with the TDP contractor’s claims and coverage decisions.

**Assignment of Benefits**
When a beneficiary signs the assignment of benefits statement on a claim form, he or she is allowing the TDP contractor to send payment directly to the dentist. If the assignment of benefits provision is not signed, the TDP contractor’s payment will be sent to the beneficiary, and he or she will be responsible for paying the dentist.

**Authorized Dentist**
A licensed dentist (DDS or DMD) or dental hygienist who provides services within the scope of his or her license or registration and who has not been excluded, suspended, or sanctioned from providing service under the TDP.

**Authorized Provider**
Any CONUS provider who is fully licensed and approved to provide dental care or covered anesthesia benefits in the state in which the provider is located, including dentists and certified registered nurse anesthetists. This also includes dental hygienists practicing within the scope of their licensure, subject to any restrictions a state licensure or legislative body imposes regarding their status as independent providers of care. Dentists currently sanctioned by U.S. Department of Health and Human Services are not authorized providers under the TDP network. Authorized providers don’t apply in the OCONUS service area.

**Beneficiary (enrollee)**
The beneficiary (enrollee) is an individual who is eligible to enroll in the TDP. Depending upon the sponsor’s status, this individual may be a sponsor, a family member, or a survivor.

**Beneficiary Counseling and Assistance Coordinator (BCAC)**
A military or government employee usually located at a military treatment facility who can address TRICARE-related issues and concerns.

**Benefits**
Dental services received by enrolled beneficiaries for which all or part of the cost is authorized and paid for by the TDP.
**Bridge**
Prosthetic (false) tooth or row of teeth that spans between two natural teeth to replace missing or lost teeth.

**By-Report Procedures**
Procedures provided in circumstances that require written justification/documentation from the treating dentist.

**Claim**
Request for payment for services rendered.

**Claim Form**
Document used either to submit a claim for payment or request a predetermination. If the date of service is left blank, the claim form is considered a predetermination request.

**Command-Sponsored**
Command-sponsored is defined as a privilege granted by the service so that the service member’s family may accompany the service member.

**CONUS Service Area**
The TDP CONUS service area includes the 50 United States, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands.

**Coordination of Benefits**
Rules that determine which plan pays benefits first and which plan pays benefits second.

**Cost-Share**
The amount the sponsor/beneficiary/patient/family member is required to pay for the services rendered. The TDP pays the other portion of the cost-share.

**Crowns**
A porcelain or gold cover for a decayed, damaged, brittle, or discolored tooth.

**Defense Enrollment Eligibility Reporting System (DEERS)**
DEERS serves as a centralized Department of Defense data repository of personnel and health care benefits distributed to uniformed services members. DEERS is a functional component of the DMDC.

**Defense Health Agency**
The government office responsible for oversight of the TDP contract.

**Dental Estimate of Benefits (Predetermination)**
Written estimate provided by the TDP contractor in response to a request by a dentist or beneficiary for an estimate of coverage for future dental services.

**Dental Explanation of Benefits (DEOB)**
Computer-generated notice mailed to beneficiaries and dentists explaining benefits determinations (for example, type of service received, the allowable charge, the amount billed, and amount payable by the TDP contractor).

**Dental Treatment Facility (DTF)**
A facility operated by the military that provides dental care to eligible TRICARE beneficiaries.

**Denture**
A removable set of artificial teeth. Dentures may be a partial, that is, replacing only a section of teeth, or full, which would replace the entire upper or lower sections of teeth.

**Diagnostic Services**
Services used to evaluate a dental prognosis. Examples can include plaster or stone models of teeth or X-rays.

**Eligibility**
The rules set forth by the government to determine which beneficiaries may be enrolled in the TDP.

**Endodontic Exclusion**
The treatment of diseases of the dental pulp (never tissue) or injuries that affect the root tip or nerve of the tooth (apex). The most common procedure that you will deal with is a root canal.

**Enrollee**
A beneficiary (member) enrolled in the TDP.
Exams
An evaluation can be either an initial (comprehensive oral evaluation) or periodic check on the condition of the mouth.

Exclusion
Service for which there is no coverage under the dental benefit plan.

Fillings
Restoring lost tooth structure with amalgam, metal, porcelain, or composite resin. Used as part of the treatment of cavities.

Fluoride Treatments
Application of fluoride (via liquid, paste, foam, or tablet) to strengthen the tooth enamel. It is used as a means to prevent dental cavities. Usually covered for dependent children only.

General Anesthesia
A controlled state of unconsciousness or “deep sleep,” accompanied by a partial or complete loss of pain sensation, as well as protective reflexes, and including a loss of ability to independently maintain a breathing airway and respond purposefully to verbal or physical stimulation.

Gingivectomy
The excision or removal of gingiva (soft tissues overlying the crowns of unerupted teeth and encircling the necks of those that have erupted).

Implant
A device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement.

Individual Ready Reserve (IRR)
The IRR consists of those members of the Ready Reserve who are not in the Selected Reserve or Inactive National Guard. See “Other than Special Mobilization Category” and “Special Mobilization Category” in this glossary.

Inlays and Onlays
Custom-made cast gold or porcelain alloy that is cemented to a previously prepared cavity in the tooth. A stronger and longer lasting alternative to amalgam or composite filling.

In-Process Orthodontic Treatment
Orthodontic treatment that began prior to the patient’s enrollment in the TDP administered by the TDP contractor.

Integral
A procedure that is considered necessary as part of another billable procedure and, therefore, not eligible for consideration for payment by the TDP.

Lock-In Period
The mandatory 12-month initial enrollment period for TDP beneficiaries.

Lock-Out Period
If you fail to pay your monthly premium(s), you will be prohibited from reenrolling in the TDP for 12 months following the last month that premiums were paid.

Maximums
Total dollar amount per beneficiary payable under the TDP by the TDP contractor. There is an annual maximum of $1,500 for all services with the exception of orthodontic treatment, which has a lifetime maximum of $1,750. There is an additional $1,200 maximum for dental care necessitated by an accident.

Member (Beneficiary)
The member (beneficiary) is an individual who is eligible to enroll in the TDP. Depending upon the sponsor’s status, this individual may be a sponsor, a family member, or a survivor.

Military Treatment Facility (MTF)
A medical facility operated by the military that may provide inpatient and/or ambulatory care to eligible TRICARE beneficiaries. MTF capabilities vary from limited acute care clinics to teaching and tertiary care medical centers.

National Guard and Reserve
The National Guard and Reserve include members of the Army National Guard, Army Reserve, Navy Reserve, Marine Corps Reserve,
Air National Guard, Air Force Reserve, and U.S. Coast Guard Reserve. (As a group, referred to as the “Reserve Component.”)

**Non-Availability and Referral Form (NARF)**

A NARF is an OCONUS form used by a TRICARE Area Office, overseas uniformed services dental treatment facility, or designated OCONUS points of contact before any orthodontic treatment can begin.

**Non-network Dentist**

A dentist who has not signed an agreement with the TDP contractor to become a network dentist.

**Occlusion**

The relationship between the teeth in the upper and lower arches at rest position; often called “the bite.”

**OCONUS Service Area**

The TDP OCONUS service area includes areas not in the CONUS service area and covered services provided on a ship or vessel outside the territorial waters of the CONUS service area, regardless of the dentist’s office address.

**Oral Exam**

An initial evaluation or periodic check on the condition of the mouth.

**Oral Surgery**

Services relating to the treatment of diseases, injuries, deformities, defects, and aesthetic aspects of the oral and maxillofacial regions.

**Orthodontic Services**

Services relating to the treatment of teeth in relation to the functions of occlusion and speech.

**Osseous Surgery**

Surgery associated with periodontal disease.

**Other Dental Insurance**

Additional coverage to the TDP through an employer, association, or private insurer. See “Coordination of Benefits” in this glossary.

**(Individual Ready Reserve)**

The majority of the individuals in the Individual Ready Reserve are in this category. Usually these members are trained and have previously served on active duty or in the Selected Reserve of the Ready Reserve. Members of this category also include some untrained individuals, personnel participating in officer training programs, and personnel awaiting initial active duty.

**Overseas Uniformed Services Dental Treatment Facility (ODTF)**

An overseas facility operated by the military that provides dental care to eligible TRICARE beneficiaries residing in overseas locations.

**Periodontal Services**

Services relating to the treatment of diseases of the supporting and surrounding tissues of the teeth.

**Permanent Change of Station (PCS)**

For the purpose of establishing an exception to certain limitations of the TDP, PCS refers to a move from one official duty station to another official duty station. PCS does not include a relocation executed under separation or retirement orders to the home of record or place of selection.

**Plan Year**

The annual beneficiary maximum ($1,300) applies to the 12-month period from May 1–April 30.

**Predetermination (Dental Estimate of Benefits)**

Written estimate provided by the TDP contractor in response to a request by a dentist or beneficiary for an estimate of coverage for future dental services. TDP predeterminations are valid for six months from the date of finalization.

**Premium**

The amount charged by an insurer in exchange for its promise to provide a policy benefit when a specific loss occurs.

**Procedure Codes**

Codes used to identify and define specific dental services.
Prophylaxis
Cleaning and removal of plaque, stains, and calculus on the teeth, performed by a dentist or dental hygienist. Ideally performed at least every six months. Also referred to as “prophy.”

Prosthetics
A fixture or removable appliance to replace missing teeth. Examples: bridges, dentures, partials.

Prosthodontic Services
Professional placement or maintenance of artificial teeth, either fixed or removable.

Provider
Providers include dentists legally able to practice dentistry, certain certified dental hygienists authorized by law to provide specified dental services, anesthesiologists, and certified registered nurse anesthetists.

Pulpotomies
Removal of a portion of the pulp, including the diseased aspect, with the intent of maintaining the vitality of the remaining pulpal tissue by means of a therapeutic dressing.

Ready Reserve
The Ready Reserve is composed of the National Guard and Reserve, organized in units or as individuals. The Ready Reserve consists of the Selected Reserve, the Individual Ready Reserve, and the Inactive National Guard.

Reconsideration
First level of the appeals process. The reconsideration enables beneficiaries and dentists to seek a separate review from the initial payment determination to assess whether the initial payment decision was correct.

Resin
A type of dental restorative material made up of disparate or separate parts.

Root Canal
Procedure used to save an abscessed tooth in which the pulp chamber is cleaned out, disinfected, and filled with a permanent filling.

Sealants
A resinous material designed to be applied to the occlusal surfaces of posterior teeth to prevent occlusal caries.

Selected Reserve of the Ready Reserve
Members in the Selected Reserve are designated as essential to initial wartime missions and have priority over all other Reserves. All Selected Reserve members are on active status.

Space Maintainers
Fixed or removable appliance designed to preserve the space created by the premature loss of a tooth.

Special Investigations Unit (SIU)
The TDP contractor’s fraud and abuse investigation department for reporting suspected fraud if a beneficiary believes a dentist or entity received insurance money through the submission of a false claim.

Special Mobilization Category (Individual Ready Reserve)
Within the Individual Ready Reserve, there is a category of members who are subject to being ordered to active duty involuntarily. The volunteer members are selected based upon the needs of the service unit and the grade and military skills of that member.

Sponsor
The uniformed service member upon whom eligibility in TDP is based.

Student
Beneficiary up to age 23 who is enrolled in a full-time course of study at an approved institution of higher learning, and for whom the sponsor provides over 50 percent of the financial support.
**TDP Enrollment Authorization Document**
The *TDP Enrollment Authorization* document is used to enroll in the TDP, to add or remove family members from a policy, to cancel a policy, and to update enrollees’ addresses and telephone numbers. The document must be submitted by the uniformed services sponsor or an individual with power of attorney.

**TDP Network Dentist**
An authorized dentist who has signed a participation agreement with the TDP contractor and who agrees to accept the TDP contractor determined allowable charge as payment in full for covered services. Network dentists agree to provide services to people in the TDP contractor dental plans at fees that are typically 10 percent to 35 percent below average charges in their communities. TDP beneficiaries who choose to visit a TDP network dentist can increase the value of their benefit plan because of the lower charges.

**Temporomandibular Joint Dysfunction (TMD)**
TMD is an acute or chronic inflammation of the temporomandibular joint—the “hinges” between the lower jawbone and the bones of the head/skull.

**TRICARE Area Office (TAO)**
TAOs are located in certain overseas areas to assist beneficiaries who live or who are traveling overseas. A TAO completes *Non-Availability and Referral Forms* for orthodontic treatment in OCONUS areas, and submits claims to the TDP contractor for reimbursement on a beneficiary’s behalf.

**TRICARE Dental Program (TDP)**
Dental plan offered by the Department of Defense through the Defense Health Agency and administered by United Concordia.

**TRICARE OCONUS Preferred Dentist (TOPD)**
TOPDs are located in select OCONUS locations who have signed an agreement with the TDP contractor to invoice the TDP contractor directly for the TDP’s share of the bill, to provide English language services, and to follow appropriate sterilization practices. TOPDs are provided to beneficiaries as a convenience. Beneficiaries are eligible to see any licensed and authorized dental provider they choose.

**TRICARE Retiree Dental Program (TRDP)**
The TRDP provides dental care for uniformed services members who are entitled to retirement pay, members of the Retired Reserve under age 60, Congressional Medal of Honor recipients, unremarried surviving spouses, and certain other eligible family members.

**TRICARE Service Center (TSC)**
The overseas region is served by TSCs, which are staffed by beneficiary service representatives who can explain the different TRICARE options and help beneficiaries choose the plan that suits them best.

**Uniformed Services**

**United Concordia**
The administrator and underwriter of the TDP.

**United Concordia Dentist Consultant**
Dentists who are contracted by United Concordia to review claim submission documents, predetermination requests, and appeals.

**X-Rays**
Radiation used for diagnostic purposes to photograph the bone tissue of the tooth above and below the gum line.
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## Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by the TRICARE Dental Program (TDP) and how it will be used.

<table>
<thead>
<tr>
<th><strong>AUTHORITY:</strong></th>
<th>10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.13, TRICARE Dental Program; 38 U.S.C. 1781, Medical Care for Survivors and Dependents of Certain Veterans; and E.O. 9397 (SSN), as amended.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PURPOSE:</strong></td>
<td>To obtain information from an individual to provide for enrollment, processing of claims, and customer service to individuals eligible for TRICARE Dental Program benefits.</td>
</tr>
<tr>
<td><strong>ROUTINE USES:</strong></td>
<td>Information collected may be used and disclosed generally as permitted under 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules, as implemented by DoD 6025.18-R, the DoD Health Information Privacy Regulation. In addition to those disclosures generally permitted under 5 U.S.C. 552a (b) of the Privacy Act of 1974, the DoD “Blanket Routine Uses” under 5 U.S.C. 552a (b) (3) apply to this collection. Information from this system may be shared with federal, state, local, or foreign government agencies, and with private business entities, including individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation.</td>
</tr>
<tr>
<td><strong>DISCLOSURE:</strong></td>
<td>Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the denial of benefits.</td>
</tr>
</tbody>
</table>
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our Legal Duty

United Concordia Companies, Inc., and its subsidiaries (referred to as United Concordia) are committed to protecting your privacy and are required by applicable federal and state laws to maintain the privacy of your protected health information. “Protected health information” is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse, that relates to: (1) your past, present, or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

We are required to give you this notice about our privacy practices, which describes how we may use, disclose, collect, handle and protect our members’ protected health information; our legal duties; and your rights concerning your protected health information. We are required to maintain the privacy of your protected health information and inform you of your right to be notified following a breach of your unsecured protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 9/23/2013 and will remain in effect until we replace it.

We will continually review our privacy practices to ensure the privacy of our members’ protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this notice at any time, provided that changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices, and the new terms of our notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. If we make a significant change in our privacy practices, we will revise this notice and notify all affected members in advance of the change. Changes to this notice will be posted on our website, and we will provide you with either the revised notice or information about the changes and how to obtain a revised notice.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

In order to administer our benefit programs effectively, we collect, use and disclose protected health information for certain of our activities, including payment and health care operations. The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations.

Payment and Health Care Operations: We may use and disclose your protected health information to pay claims for services provided to you by providers covered by your plan to: determine your eligibility for benefits, coordinate benefits, examine medical necessity, obtain premiums and/or issue explanations of benefits. We may use and disclose your protected health information to: conduct quality assessment and improvement activities, engage in care coordination or case management, manage our business and rate our
risk and determine the premium for your health plan. However, we may not use or disclose your protected health information that is genetic information for underwriting purposes. We may use and/or disclose your protected health information for all activities that are included within the definition of “payment” and “health care operations,” but we have not listed all of the activities in this notice so please refer to 45 C.F.R. § 164.501 for a complete list.

**Business Associates:** In connection with our payment and health care operations activities, we contract with individuals and entities (called “business associates”) to perform various functions on our behalf, or to provide certain types of services (such as member service support, utilization management or subrogation). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

**Other Covered Entities:** In addition, we may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain of their health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

**Other Possible Uses and Disclosures of Protected Health Information**

In addition to uses and disclosures for payment and health care operations, we may use and/or disclose your protected health information for the following purposes.

**To Plan Sponsors:** We may disclose your protected health information and the protected health information of others enrolled in your group plan to the plan sponsor to perform plan administration functions. We may also disclose summary health information to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan, or to decide whether to modify, amend or terminate your group health plan. Please see your plan documents for a full explanation of the limited uses and disclosures that the plan sponsor may make of your protected health information in providing plan administration functions for your group plan.

**Benefits and Services:** We may use your protected health information to contact you with information about health-related benefits and services, or about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities.

**Others Involved in Your Health Care:** Unless you object, we may release protected health information about you to a friend or family member who is involved in your health care, or to someone who helps pay for your care. We may also disclose protected health information about you to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status or location.

**Research, Death:** We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, medical examiner or funeral director.

**Public Health and Safety:** We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the healthcare system, or government programs or its contractors, and to public health authorities for public health purposes. We may disclose your protected health information to appropriate authorities if we reasonably believe
that you are a possible victim of abuse, neglect, domestic violence or other crimes.

**Required by Law:** We may use or disclose your protected health information when we are required to do so by law. For example we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

**Workers’ Compensation:** We may disclose your protected health information to comply with workers’ compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

**To You and on Your Authorization:** We must disclose your protected health information to you, as described in the Individual Rights section of this notice below. You may give us written permission to use your protected health information or to disclose it to anyone for any purpose. We may use or disclose to a business associate or to an institutionally related foundation, your protected health information for the purpose of raising funds on our behalf. With each fundraising communication we will provide you with the opportunity to elect not to receive any further fundraising communications. Uses and disclosures for marketing purposes, disclosures that constitute a sale of protected health information and other uses and disclosures not described within this notice will only be made with your written authorization. If you give us authorization, you may change your mind at any time. Your decision to revoke your prior authorization will not affect any use or disclosures made while it was in effect.

**Individual Rights**

**Access:** You have the right to inspect and copy protected health information about you in a designated record set that may be used to make decisions about your care. To inspect and copy protected health information, you must submit your request in writing to the Privacy Office. You may request that we provide copies in a format other than paper. We will use the format you request unless we cannot practicably do so. We may charge a fee for the costs of copying, mailing or other costs associated with your request. We may deny your request to inspect and copy in certain limited circumstances. If your request is denied, you may request a review of that decision. Under certain conditions, our denial will not be reviewable and we will inform you of that with our decision. The healthcare professional conducting the review will not be the person who denied your initial request. We will comply with the outcome of the review.

**Accounting:** You have the right to receive a list of instances in which we disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities. Your request may be for disclosures made up to 6 years before the date of your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure and certain other information. The first list you request will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact the Privacy Office for information on these fees.

**Restriction:** You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these restrictions. If we do, we will follow our agreement, unless the information is needed to provide emergency treatment to you. A request to restrict your protected health information, must be made in writing and must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. We will notify you if we end our agreement with you to restrict your protected health information.

**Confidential Communications:** If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information.
health information by alternative means or to an alternative location. For example you may ask that we contact you only at your work address or via your work e-mail. Your request must be in writing and must state that the information could endanger you if it is not communicated in confidence by the alternative means or location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may submit in writing a statement disagreeing with the denial, which we will add to the information you wanted to amend. If we accept your request, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Paper Copy of This Notice: You have the right to a paper copy of this notice, and you may ask us to give you a copy of this notice at any time. You may obtain an electronic copy of this notice on our website.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights or you disagree with: (1) a decision we made about access to your protected health information, (2) our response to a request you made to amend or restrict the use or disclosure of your protected health information, or (3) our response to your request to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: United Concordia Privacy Dept.
Telephone: 1-866-215-2352 (Toll Free)
Fax: 1-717-260-7494
Website: www.unitedconcordia.com
Address: 4401 Deer Path Road
Harrisburg, PA 17110

United Concordia Companies, Inc., and Subsidiaries
United Concordia Dental Plans, Inc.
United Concordia Dental Corporation of Alabama
United Concordia Dental Plans of California, Inc.
United Concordia Dental Plans of Kentucky, Inc.
United Concordia Dental Plans of the Midwest, Inc.
United Concordia Dental Plans of Pennsylvania, Inc.
United Concordia Dental Plans of Texas, Inc.
United Concordia Insurance Company
United Concordia Life and Health Insurance Company
United Concordia Insurance Company of New York
According to the Department of Defense (DoD), as a TRICARE beneficiary, you should expect to have the following abilities and support:

- **Get information**: You should expect to receive accurate, easy-to-understand information from written materials, presentations, and TRICARE representatives to help you make informed decisions about TRICARE programs, medical professionals, and facilities.

- **Choose providers and plans**: You should expect a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.

- **Emergency care**: You should expect to access medically necessary and appropriate emergency health care services as is reasonably available when and where the need arises.

- **Participate in treatment**: You should expect to receive and review information about the diagnosis, treatment, and progress of your conditions, and to fully participate in all decisions related to your health care, or to be represented by family members or other duly appointed representatives.

- **Respect and nondiscrimination**: You should expect to receive considerate, respectful care from all members of the health care system without discrimination based on race, color, national origin, or any other basis recognized in applicable law or regulations.

- **Confidentiality of health information**: You should expect to communicate with health care providers in confidence and to have the confidentiality of your health care information protected to the extent permitted by law. You also should expect to have the ability to review, copy, and request amendments to your medical records.

- **Complaints and appeals**: You should expect a fair and efficient process for resolving differences with health plans, health care providers, and institutions that serve you.

Additionally, the DoD has the following expectations of you as a TRICARE beneficiary:

- **Maximize your health**: You should maximize healthy habits, such as exercising, not smoking, and maintaining a healthy diet.

- **Make smart health care decisions**: You should be involved in health care decisions, which means working with providers to provide relevant information, clearly communicate wants and needs, and develop and carry out agreed-upon treatment plans.

- **Be knowledgeable about TRICARE**: You should be knowledgeable about TRICARE coverage and program options.

- **You also should**:
  - Show respect for other patients and health care workers
  - Make a good-faith effort to meet financial obligations
  - Use the disputed claims process when there is a disagreement
Directory of Resources

**Online**
Visit www.tricare.mil/dental or www.uccitdp.com

**CONUS**

**Claim Submissions**
United Concordia TRICARE Dental Program
P.O. Box 69451
Harrisburg, PA 17106
Fax: 1-717-635-4565

**Customer Service**
1-844-653-4061 (toll-free)
Sunday 6 p.m.–Friday 10 p.m. (ET), except holidays
United Concordia TDD/TTY service for the hearing impaired: 711

**OCONUS**

**Claim Submissions**
United Concordia TRICARE Dental Program
P.O. Box 69452
Harrisburg, PA 17106
Fax: 1-844-827-9926

**Customer Service**
1-844-653-4060 (toll-free)
1-717-888-7400 (toll)
Representatives are available to assist beneficiaries in English, German, Italian, Japanese, Korean and Spanish, Sunday 6 p.m.–Friday 10 p.m. (ET), except holidays
United Concordia TDD/TTY service for the hearing impaired: 711

**Quality of Care**

**Inquiries**
United Concordia
TDP Grievances
1800 Center Street 2AL4
Camp Hill, PA 17089
Fax: 1-717-260-7168

**Enrollment and Billing Services**

**Enrollment Forms**
United Concordia
TRICARE Dental Program
P.O. Box 645547
Pittsburgh, PA 15264
CONUS: 1-844-653-4061 (toll-free)
OCONUS: 1-844-653-4060 (toll-free)
1-717-888-7400 (toll)
United Concordia TDD/TTY service for the hearing impaired: 711

**Billing Payments**
United Concordia Companies, Inc.
P.O. Box 645534
Pittsburgh, PA 15264

**Fraud and Abuse Issues**

**Inquiries**
United Concordia
Special Investigations Unit—TDP
4401 Deer Path Road DP3B
Harrisburg, PA 17110

**Fraud Hotline**
1-877-968-7455 (toll-free)

**Other TRICARE-Related Listings**

**Defense Manpower Data Center Support Office**
Defense Manpower Data Center Support Office
400 Gigling Road
Seaside, CA 93955-6771
Verify Eligibility: 1-800-538-9552

**Dental Provider Listings**
Visit www.uccitdp.com