DENTAL

TRICARE®
Dental Program Benefit Booklet Supplement

These pages contain updated information and expanded details about your benefit under the TRICARE Dental Program. Keep these pages with your TRICARE Dental Program Benefit Booklet *for future reference.*

TRICARE®

DEPARTMENT OF DEFENSE · UNITED STATES OF AMERICA

Important Clarification on Automatic TRICARE Dental Program Enrollment for Children Under Age 4

Protecting your children's teeth and having dental coverage for them are important aspects of oral health. That's why children are automatically enrolled in the TRICARE Dental Program (TDP):

- When two or more family members over age 4, residing at the same location, are enrolled in the TDP, then all eligible family members are automatically enrolled in the TDP, even newborns once they are added to the Defense Enrollment Eligibility Reporting System (DEERS).
- When there is an active TDP single-enrollment plan in place, once a child reaches age 4, all eligible family members under age 4 will automatically be enrolled in the TDP, making the plan a family plan.

Additionally, when there is an active TDP single-enrollment plan in place, you can request to add a child under age 4 at any time, as long as the child is listed in DEERS. The premium will change from the single-enrollment plan to the family-enrollment plan. Call MetLife or visit **www.tricare.mil/bwe** to enroll any child under age 4.

Using the TRICARE Dental Program

Network Providers

When using a network provider, you should never pay more than the applicable cost-share for covered services subject to applicable maximums, limitations, exclusions, and/or alternate benefits.

Important Clarification to Exclusions on Booklet Page 19

Certain dental procedures (*when performed on a TDP patient*) are not covered by the TDP and may be specifically excluded from TDP coverage. In these cases, prior authorization is required before a dentist performs the dental procedure(s). Procedure examples include cosmetic dental services, adult orthodontics for a person over age 23, medical procedures, and/or alternate benefits (*when based on patient preference*). This includes if the care delivered exceeded the benefit frequency limitation. For example, if a beneficiary receives three cleanings within a 12-month period and the benefit allows for coverage of two within a 12-month period, the beneficiary is responsible for the cost of the third prophylaxis, regardless of whether or not the beneficiary was notified that the care would exceed the frequency limitation.

Non-Covered Services

Treatment rendered by a dentist or physician who is a close relative, including spouse, child, adopted child, step-relative, sibling, parent, or grandparent of the beneficiary, will be declined as a non-covered benefit under the TDP.

TRICARE Dental Program OCONUS

Important Clarification to OCONUS Dentists on Booklet Page 15

TRICARE OCONUS Preferred Dentists (TOPDs) have agreed not to require you to pay their full charge at time of service, only your applicable cost-share, if any; that they will complete and submit your claims to MetLife; and that payment will be made directly to TOPDs unless you submit a receipt for services rendered, in which case, payment will be made to you.

OCONUS Claims

When filing OCONUS claims, note that if a service or procedure is considered part of another procedure, the fees will be combined and considered under the most comprehensive procedure. For example, if local anesthesia and an extraction are submitted on the claim, the fee for the local anesthesia will be added to the fee for the extraction.

Inside the Supplement

MetLife and Other Dental Insurance

(*Important Clarification to Coordination of Benefits Scenarios on Booklet Page 51*)

Below are some scenarios that describe fees and payment amounts for beneficiaries who use MetLife and another primary insurance provider (*MetLife is the secondary payer*).

To properly determine benefits payable by MetLife as the secondary payer, any claims submitted to MetLife must also include an explanation of benefits statement from the primary insurance provider, which shows the dentist's fee allowance and the amount that the primary insurer paid.

Service	Dentist Original Fee Charged[1]	MetLife Network Fee	Primary Insurer's Network Fee	Primary Insurance Payment Amount	MetLife Payment Amount	Your Payment Due
Scenario 1: The dentist is not a network provider within the primary insurer's network or MetLife's network. MetLife is responsible for remaining costs toward the dentist's original fee charged.						
Crown (*50% cost-share*)	$900	N/A	N/A	$450	$450	$0
Scenario 2: The dentist is not a network provider under the primary insurer, but is a MetLife network provider. MetLife is responsible for remaining costs toward the MetLife network fee.						
Crown (*50% cost-share*)	$900	$800	N/A	$400	$400	$0
Scenario 3: The dentist is a network provider under the primary insurer, but is not a MetLife network provider. MetLife is responsible for remaining costs toward the primary insurer's network fee.						
Crown (*50% cost-share*)	$900	N/A	$800	$400	$400	$0
Scenario 4: The dentist is a network provider within the primary insurer's network and the MetLife network. MetLife is responsible for remaining costs toward the highest network fee, whether it's the primary insurer's fee or MetLife's fee.						
Crown (*50% cost-share*)	$900	$800	$700	$400	$400	$0

*1. "Dentist Original Fee Charged" refers to the amount the dentist charges for a service. Please note that when a dentist is a network provider with the primary insurer or MetLife (*secondary insurer*), the dentist may be contractually obligated to limit charges to either the primary or secondary insurer carrier's network fee. The examples above assume that the "Dentist Original Fee Charged" is an average fee for a given service.*

Booklet Coverage Updates

Section 5 and Section 6

The following pages of this supplement contain updates to sections 5 and 6 (*pages 16–42*) of the booklet. Changes are indicated by use of purple text.

Section 16

The updated "HIPAA Notice of Privacy Practices for Protected Health Information" appears at the end of this supplement.

Your Costs and Fees

Premiums

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

TDP Beneficiary Premium Shares *Figure 5.1*

Beneficiary Category	Premium Share
Family members of active duty service members or active National Guard or Reserve sponsors	60% government 40% beneficiary
Selected Reserve of the Ready Reserve and Individual Ready Reserve (IRR) (*special mobilization category*) sponsors	60% government 40% beneficiary
IRR (*non-special mobilization category*) sponsors	100% beneficiary
Selected Reserve and IRR family members	100% beneficiary
Eligible Survivors	100% government

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 February 1. Visit **www.tricare.mil/costs** for details.

Premium Payroll Allotments

If the sponsor has a military payroll account, and if sufficient funds are available, the government will collect the sponsor's share of the premium through a Uniformed Services Finance Center.

If MetLife is unable to obtain the requested premium payment from the sponsor's military payroll account for any reason, the sponsor will be responsible for paying the premium costs by direct billing by MetLife or by a second attempt through the payroll account.

Direct Billing Process

The following payment methods are available for sponsors with insufficient funds in their military 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 Web site accessible at **www.tricare.mil/bwe**, or over the phone.
- **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 contact information and 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 MetLife will pay the dentist for the particular procedure performed. For Preferred Dentist Program (PDP) 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 TRICARE Dental Program (TDP) 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 $1,300 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 February 1.

Lifetime Maximum Benefit for Orthodontic Treatment

For orthodontic treatment, there is a $1,750 OLM benefit per beneficiary. Orthodontic diagnostic services will be applied to the $1,300 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 $1,300 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 MetLife'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 MetLife nor will the government pay for any costs once the maximum has been met.

Note: Only MetLife'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 a member is required to pay for the services received. MetLife's payment is based upon the allowable charge (*allowed fee*). The allowable charge is the amount MetLife will consider for a particular procedure performed. For PDP 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 PDP 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 members may 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 MetLife's allowed fee for treatment.

Beneficiary Cost-Shares Summary Chart *Figure 5.2*

Covered Services	Cost-Share for Pay Grades E-1–E-4	Cost-Share for All Other Pay Grades (*E-5 and above*)	Cost-Share for OCONUS Command Sponsored Beneficiaries[1]
Diagnostic	0%	0%	0%
Preventive[2]	0%	0%	0%
Sealants	20%	20%	0%
Basic restorative	20%	20%	0%
Endodontic	30%	40%	0%
Periodontic	30%	40%	0%
Oral surgery	30%	40%	0%
Miscellaneous services (*occlusal guard, athletic mouth guard*)	50%	50%	0%
Other restorative	50%	50%	50%
Implant services	50%	50%	50%
Prosthodontic	50%	50%	50%
Orthodontic[3]	50%	50%	50%

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 without cost-shares for patients under age 19. Sealants are covered at a 20 percent cost-share 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.*

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. Network dentists may not bill MetLife or the patient for the completion of claim submission documents and submission of required information for determination of benefits.
9. 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.
10. Local anesthesia is considered integral to the procedure(s) for which it is provided.
11. 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.
12. 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 2012 and receives a cleaning on May 13, 2012, and again on January 10, 2013, he or she would be eligible for the next cleaning on May 1, 2013. If he or she chooses to have a cleaning in April 2013, 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*).

13. The 24-month limitation for periodontal services (*e.g., 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, 2012, scaling and root planing in the same area of the mouth would not be eligible until September 10, 2014.

14. 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 a member received a complete series of X-rays on May 15, 2012, he or she would be eligible for another complete series of X-rays, or a panoramic X-ray, on May 1, 2015.

15. 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, 2012, a replacement sealant would not be eligible until June 11, 2015.

16. The five-year time limitation for other restorative services (*e.g., crowns, onlays, etc.*) and prosthodontic services (*e.g., dentures, fixed bridges, etc.*) 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, 2012, a replacement denture would not be eligible until June 15, 2017.

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

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

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

20. 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 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, MetLife will request that dentists submit all X-rays used for diagnosis and treatment planning.

It is MetLife'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 as to why.

"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 MetLife. All claims received from the OCONUS service area will be processed without a report requirement.

Diagnostic Services

Diagnostic Services Codes *Figure 6.1*

Code	Description of Service
D0120[1]	Periodic oral evaluation—established patient
D0140	Limited oral evaluation—problem-focused
D0145[1]	Oral evaluation for a patient under age 3 and counseling with primary caregiver
D0150[1]	Comprehensive oral evaluation—new or established patient
D0160 R	Detailed and extensive oral evaluation—problem-focused, by report
D0180	Comprehensive periodontal evaluation—new or established patient
D0210[1]	Intraoral—complete series complete series (*including bitewings*) of radiographic images
D0220[1]	Intraoral—periapical first radiographic image
D0230[1]	Intraoral—periapical—each additional radiographic image
D0240[1]	Intraoral—occlusal radiographic image
D0250	Extraoral—first radiographic image
D0260	Extraoral—each additional radiographic image
D0270[1]	Bitewing—single radiographic image
D0272[1]	Bitewings—two radiographic images
D0273[1]	Bitewings—three radiographic images
D0274[1]	Bitewings—four radiographic images
D0290	Posterior-anterior or lateral skull and facial bone survey radiographic image
D0330[1]	Panoramic radiographic image
D0340	Cephalometric radiographic image
D0425[1]	Caries susceptibility tests
R = 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 radiographic image 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 participating 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 MetLife. Patient-specific rationale (*specific signs or symptoms*) must be submitted for review. If denied, a participating 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 radiographic images, 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. Posterior-anterior or lateral skull and facial bone survey films (*D0290*) and cephalometric radiographic images (*D0340*) are each covered once per 12-month period. They are not covered for the diagnosis or treatment of TMD.
22. Cephalometric radiographic images are covered for patients under age 23.
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 regimen. 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 *Figure 6.2*

Code	Description of Service
D1110[1]	Prophylaxis—adult
D1120[1]	Prophylaxis—child
D1206[1]	Topical application of fluoride varnish
D1208	Topical application of fluoride
D1510	Space maintainer—fixed—unilateral
D1515	Space maintainer—fixed—bilateral
D1520	Space maintainer—removable—unilateral
D1525	Space maintainer—removable—bilateral
D1550	Recementation of space maintainer
D1555	Removal of fixed space maintainer
D1999	Unspecified preventive procedure, by report

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 submission document.
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. The dentist must indicate the medical diagnosis code on the claim submission document. Enrollees should ensure that the medical diagnosis is noted clearly on the claim submission document.
5. Routine prophylaxes may be allowed when eligible and when performed by the same dentist on the same day as partial quadrant scaling and root planing (*D4342*) and partial quadrant periodontal surgery (*D4211, D4241, D4261*) because the remaining healthy teeth in the quadrants still may need prophylaxes.
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. Periodontal scaling in the presence of gingival inflammation is considered to be a routine prophylaxis and is paid as such. Network dentists may not bill the patient for any difference in fees.
9. Two topical fluoride applications are covered in a consecutive 12-month period.
10. 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.
11. Space maintainers are fully covered, without cost shares, for patients under age 19.
12. Repair of a damaged space maintainer is not a covered benefit.
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 *Figure 6.3*

Code	Description of Service
D1351	Sealant—per tooth
D1352	Preventive resin restoration in a moderate-to-high caries risk patient—permanent tooth

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 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*).

Restorative Services

Restorative Services Codes *Figure 6.4*

Code	Description of Service
D2140	Amalgam—one surface, primary or permanent
D2150	Amalgam—two surfaces, primary or permanent
D2160	Amalgam—three surfaces, primary or permanent
D2161	Amalgam—four or more surfaces, primary or permanent
D2330	Resin-based composite—one surface, anterior
D2331	Resin-based composite—two surfaces, anterior
D2332	Resin-based composite—three surfaces, anterior

Restorative Services Codes (continued)

Code	Description of Service
D2335	Resin-based composite—four or more surfaces or involving incisal angle (*anterior*)
D2390	Resin-based composite crown, anterior
D2391	Resin-based composite—one surface, posterior
D2392	Resin-based composite—two surfaces, posterior
D2393	Resin-based composite—three surfaces, posterior
D2930	Prefabricated stainless-steel crown—primary tooth
D2931	Prefabricated stainless-steel crown—permanent tooth
D2932	Prefabricated resin crown
D2933	Prefabricated stainless-steel crown with resin window
D2951	Pin retention—per tooth, in addition to restoration

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 member 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 member is responsible for the difference between the dentist's charge for the resin restoration and the amount paid by MetLife 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 MetLife.
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 MetLife. 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 MetLife for the stainless-steel crown.

21. Temporary crowns placed on fractured teeth (*D2970*) are eligible once per tooth per lifetime. They are considered integral to crown fabrication when provided by the same office that provides the final crown.

Other Restorative Services

Other Restorative Services Codes *Figure 6.5*

Code	Description of Service
D2542 X	Onlay—metallic—two surfaces
D2543 X	Onlay—metallic—three surfaces
D2544 X	Onlay—metallic—four or more surfaces
D2642 X	Onlay—porcelain/ceramic—two surfaces
D2643 X	Onlay—porcelain/ceramic—three surfaces
D2644 X	Onlay—porcelain/ceramic—four or more surfaces
D2662 X	Onlay—resin-based composite—two surfaces
D2663 X	Onlay—resin-based composite—three surfaces
D2664 X	Onlay—resin-based composite—four or more surfaces
D2740 X	Crown—porcelain/ceramic substrate
D2750 X	Crown—porcelain-fused to high-noble metal
D2751 X	Crown—porcelain-fused to predominantly base metal
D2752 X	Crown—porcelain-fused to noble metal
D2780 X	Crown—3/4 cast high-noble metal
D2781 X	Crown—3/4 cast predominantly base metal
D2782 X	Crown—3/4 cast noble metal
D2783 X	Crown—3/4 porcelain/ceramic
D2790 X	Crown—full-cast high-noble metal
D2791 X	Crown—full-cast predominantly base metal
D2792 X	Crown—full-cast noble metal
D2794 X	Crown—titanium

Other Restorative Services Codes (continued)

Code	Description of Service
D2910	Recement inlay, onlay, or partial coverage restoration
D2915	Recement cast or prefabricated post and core
D2920	Recement crown
D2941	Interim therapeutic restoration—primary dentition
D2950 X	Core buildup, including any pins, when required
D2954 X	Prefabricated post and core in addition to crown
D2960 X	Labial veneer (*resin laminate*)—chairside
D2961 X	Labial veneer (*resin laminate*)—laboratory
D2962 XR	Labial veneer—porcelain laminate—laboratory
D2970	Temporary crown (*fractured tooth*)
D2980	Crown repair, necessitated by restorative material failure
D2982 R	Onlay repair necessitated by restorative material failure
D2983 R	Veneer repair necessitated by restorative material failure
D2990	Resin infiltration of incipient smooth surface lesions

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

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 members age 12 or younger are excluded from coverage, unless specific rationale is provided indicating the

reason for such treatment (*e.g., fracture, endodontic therapy, etc.*) and is approved by MetLife.

4. Core buildups (*D2950*) refers to the building up of coronal structure when there is insufficient retention for a separate extracornal restorative procedure. A core buildup is not a filler used to eliminate any undercut, box form, or concave irregularity in a 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 MetLife 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 member 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 (*i.e., 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 member 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 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 (*e.g., 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 on fractured teeth (*D2970*) are eligible once per tooth per lifetime. They are considered integral to crown fabrication when provided by the same office that provides the final crown.
12. Temporary crowns placed in preparation for a permanent crown are considered integral to the placement of the permanent crown.
13. Recementation of single prosthetics (*D2910, D2915, D2920*) is eligible once per six-month period. Recementation provided within 12 months of placement by the same dentist is considered integral.
14. 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.
15. 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.
16. 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.

17. 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.
18. 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.
19. 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.
20. Glass ionomer restorations will be paid based upon the fees for amalgam restorations for posterior teeth or resin restorations for anterior teeth.
21. Placement of an adhesive restorative material (*D2941*) following caries debridement, by hand or other method, for the management of early childhood caries. Not considered a definitive restoration.

Endodontic Services

Endodontic Services Codes *Figure 6.6*

Code	Description of Service
D3120	Pulp cap—indirect (*excluding final restoration*)
D3220	Therapeutic pulpotomy (*excluding final restoration*)
D3221	Pulpal debridement—primary and permanent teeth
D3222	Partial pulpotomy for apexogenesis—permanent tooth with incomplete root development

Endodontic Services Codes (continued)

Code	Description of Service
D3230	Pulpal therapy (*resorbable filling*)—anterior, primary tooth (*excluding final restoration*)
D3240	Pulpal therapy (*resorbable filling*)—posterior, primary tooth (*excluding final restoration*)
D3310	Anterior root canal (*excluding final restoration*)
D3320	Bicuspid root canal (*excluding final restoration*)
D3330	Molar root canal (*excluding final restoration*)
D3332 XR	Incomplete endodontic therapy; inoperable, unrestorable, or fractured tooth
D3333 XR	Internal root repair of perforation defects
D3346	Retreatment of previous root canal therapy—anterior
D3347	Retreatment of previous root canal therapy—bicuspid
D3348	Retreatment of previous root canal therapy—molar
D3351	Apexification/recalcification—initial visit
D3352	Apexification/recalcification—interim medication replacement
D3353	Apexification/recalcification—final visit (*includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption*)
D3355	Pulpal regeneration—initial visit
D3356	Pulpal regeneration—interim medication replacement
D3357	Pulpal regeneration—completion of treatment
D3410	Apicoectomy—anterior
D3421	Apicoectomy—bicuspid (*first root*)
D3425	Apicoectomy—molar (*first root*)
D3426	Apicoectomy (*each additional root*)
D3427	Periradicular surgery without apicoectomy
D3428	Bone graft in conjunction with periradicular surgery—per tooth, single site

Endodontic Services Codes (continued)

Code	Description of Service
D3429	Bone graft in conjunction with periradicular surgery—each additional contiguous tooth in the same surgical site
D3430	Retrograde filling—per root
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery
D3450	Root amputation—per root
D3920	Hemisection (*including any root removal*)—not including root canal therapy

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

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 members 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 member.
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 in which the intra-canal medication is replaced with new medication. Includes any necessary radiographs.
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.
22. Bone graft (*D3428, D3429*) includes non-autogenous graft material.

Periodontal Services

Periodontal Services Codes *Figure 6.7*

Code	Description of Service
D4210 XC	Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth bounded spaces per quadrant
D4211 XC	Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth bounded spaces per quadrant
D4240 XC	Gingival flap procedure, including root planing—four or more contiguous teeth or bound teeth spaces per quadrant
D4241 XC	Gingival flap procedure, including root planing—one to three contiguous teeth or bound teeth spaces per quadrant
D4249 X	Clinical crown lengthening—hard tissue
D4260 XC	Osseous surgery (*including flap entry and closure*)—four or more contiguous teeth or bound teeth spaces per quadrant

Periodontal Services Codes (continued)

Code	Description of Service
D4261 XC	Osseous surgery (*including flap entry and closure*)—one to three contiguous teeth or bound teeth spaces per quadrant
D4263 XC	Bone replacement graft—first site in quadrant
D4264 XC	Bone replacement graft—each additional site in quadrant
D4266 XC	Guided tissue regeneration—resorbable barrier, per site
D4267 XC	Guided tissue regeneration—nonresorbable barrier, per site (*includes membrane removal*)
D4270 C	Pedicle soft-tissue graft procedure
D4275 C	Soft-tissue allograft
D4277 C	Free soft tissue graft procedure (*including donor site surgery*), first tooth, or edentulous tooth position in a graft
D4278 C	Free soft tissue graft procedure (*including donor site surgery*), each additional contiguous tooth or edentulous tooth position in same graft site
D4341 XC	Periodontal scaling and root planing—four or more teeth per quadrant
D4342 XC	Periodontal scaling and root planing—one to three teeth per quadrant
D4355	Full-mouth debridement to enable comprehensive evaluation and diagnosis, covered once per 24-month period
D4910	Periodontal maintenance
D4920	Unscheduled dressing change (*by someone other than treating dentist or their staff*)

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

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 members under age 30. Only periodontal charting is required for patients over age 30.

For beneficiaries diagnosed with diabetes (*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, 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 a connective tissue graft (*D4273*) site will be processed as a one site benefit when the graft(s) area includes two contiguous teeth.
7. Subepithelial connective tissue grafts (*D4273*) and combined connective tissue and double pedicle grafts (*D4276*) are payable at the same allowance as free soft-tissue grafts (*D4277, D4278*). The difference between the allowance for the soft-tissue graft and the dentist's charge is the patient's responsibility.
8. Bone replacement grafts (*D4263*). This procedure involves the use of grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. Other separate procedures delivered concurrently are documented with their own codes.
9. (*D4264*). This procedure involves the use of grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. This procedure is performed concurrently with one or more bone replacement grafts to document the number of sites involved.
10. Bone grafts provided for ridge preservation (*D7953*) are covered when eligible and necessary in relation to the placement of a dental implant and will be covered at the same benefit level as dental implants.
11. A single site for reporting bone-replacement grafts consists of one contiguous area, regardless of the number of teeth (*e.g., 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.
12. Osseous surgery is not covered when provided within 24 months of osseous surgery in the same area of the mouth.
13. 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.
14. One crown lengthening per tooth, per lifetime, is covered.
15. Guided tissue regeneration is only covered when provided to treat specific types of periodontal defects (*i.e., 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.

16. Periodontal scaling and root planing is indicated to treat periodontal disease, which generally does not occur with frequency in younger patients. Periodontal scaling and root planing submitted for members under age 30 should be accompanied by X-rays and periodontal charting.
17. 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.
18. When partial periodontal surgical services (*D4211, D4241, and D4261*) are rendered and the remaining teeth in the quadrant that were not treated surgically but need scaling and root planing that the benefit for partial quadrant scaling and root planing (*D4342*) may be available for benefits for those teeth if eligible.
19. Beneficiaries diagnosed with diabetes 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 submission document.
20. 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.
21. 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.
22. Periodontal maintenance is generally covered when performed following active periodontal treatment.
23. Periodontal maintenance provided on the same day as periodontal scaling and root planing is considered integral.
24. 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.
25. 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, only the most comprehensive service may be eligible for benefits.
26. Procedures related to the placement of an implant (*e.g., bone recontouring and excision of gingival tissue*) are not covered.
27. Surgical revision procedure (*D4268*) is considered integral to all other periodontal procedures.
28. Full-mouth debridement to enable comprehensive evaluation and diagnosis (*D4355*) is covered once within a consecutive 24-month period.
29. 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

Prosthodontics, Removable Services Codes ***Figure 6.8***

Code	Description of Service
D5110	Complete denture—maxillary
D5120	Complete denture—mandibular
D5130	Immediate denture—maxillary
D5140	Immediate denture—mandibular

Prosthodontics, Removable Services Codes (continued)

Code	Description of Service
D5211	Maxillary partial denture—resin base (*including conventional clasps, rests, and teeth*)
D5212	Mandibular partial denture—resin base (*including conventional clasps, rests, and teeth*)
D5213	Maxillary partial denture—cast-metal framework with resin denture bases (*including conventional clasps, rests, and teeth*)
D5214	Mandibular partial denture—cast-metal framework with resin denture bases (*including conventional clasps, rests, and teeth*)
D5410	Adjust complete denture—maxillary
D5411	Adjust complete denture—mandibular
D5421	Adjust partial denture—maxillary
D5422	Adjust partial denture—mandibular
D5510	Repair broken complete denture base
D5520	Replace missing or broken teeth—complete denture (*each tooth*)
D5610	Repair resin denture base
D5620	Repair cast framework
D5630	Repair or replace broken clasp
D5640	Replace broken teeth—per tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture
D5670	Replace all teeth and acrylic on cast-metal framework (*maxillary*)
D5671	Replace all teeth and acrylic on cast-metal framework (*mandibular*)
D5710	Rebase complete maxillary denture
D5711	Rebase complete mandibular denture
D5720	Rebase maxillary partial denture
D5721	Rebase mandibular partial denture
D5730	Reline complete maxillary denture (*chairside*)
D5731	Reline complete mandibular denture (*chairside*)
D5740	Reline maxillary partial denture (*chairside*)

Prosthodontics, Removable Services Codes (continued)

Code	Description of Service
D5741	Reline mandibular partial denture (*chairside*)
D5750	Reline complete maxillary denture (*laboratory*)
D5751	Reline complete mandibular denture (*laboratory*)
D5760	Reline maxillary partial denture (*laboratory*)
D5761	Reline mandibular partial denture (*laboratory*)
D5810	Interim complete denture (*maxillary*)
D5811	Interim complete denture (*mandibular*)
D5820	Interim partial denture (*maxillary*)
D5821	Interim partial denture (*mandibular*)
D5850	Tissue conditioning (*maxillary*)
D5851	Tissue conditioning (*mandibular*)
D5863	Overdenture—complete maxillary
D5864	Overdenture—partial maxillary
D5865	Overdenture—complete mandibular
D5866	Overdenture—partial mandibular

Prosthodontics, Fixed Services

Prosthodontics, Fixed Services Codes *Figure 6.9*

Code	Description of Service
D6210 X	Pontic—cast high-noble (*gold*) metal
D6211 X	Pontic—cast predominantly base (*lead*) metal
D6212 X	Pontic—cast noble metal
D6214 X	Pontic—titanium
D6240 X	Pontic—porcelain fused to high-noble metal (*porcelain over gold*)
D6241 X	Pontic—porcelain fused to predominantly base metal
D6242 X	Pontic—porcelain fused to noble metal
D6245 X	Pontic—porcelain/ceramic
D6545 X	Retainer—cast metal for resin-bonded fixed prosthesis
D6548 X	Retainer—porcelain/ceramic for resin-bonded fixed prosthesis
D6600 X	Inlay—porcelain/ceramic, two surfaces

Prosthodontics, Fixed Services Codes (continued)

Code	Description of Service
D6601 X	Inlay—porcelain/ceramic, three or more surfaces
D6602 X	Inlay—cast high-noble metal, two surfaces
D6603 X	Inlay—cast high-noble metal, three or more surfaces
D6604 X	Inlay—cast predominantly base metal, two surfaces
D6605 X	Inlay—cast predominantly base metal, three or more surfaces
D6606 X	Inlay—cast noble metal, two surfaces
D6607 X	Inlay—cast noble metal, three or more surfaces
D6624 X	Inlay—titanium
D6608 X	Onlay—porcelain/ceramic, two surfaces
D6609 X	Onlay—porcelain/ceramic, three or more surfaces
D6610 X	Onlay—cast high-noble metal, two surfaces
D6611 X	Onlay—cast high-noble metal, three or more surfaces
D6612 X	Onlay—cast predominantly base metal, two surfaces
D6613 X	Onlay—cast predominantly base metal, three or more surfaces
D6614 X	Onlay—cast noble metal, two surfaces
D6615 X	Onlay—cast noble metal, three or more surfaces
D6634 X	Onlay—titanium
D6740 X	Crown—porcelain/ceramic
D6750 X	Crown—porcelain fused to high-noble metal
D6751 X	Crown—porcelain fused to predominantly base metal
D6752 X	Crown—porcelain fused to noble metal
D6780 X	Crown—3/4 cast high-noble metal
D6781 X	Crown—3/4 cast predominantly base metal
D6782 X	Crown—3/4 cast noble metal
D6783 X	Crown—3/4 porcelain/ceramic
D6790 X	Crown—full-cast high-noble metal

Prosthodontics, Fixed Services Codes (continued)

Code	Description of Service
D6791 X	Crown—full-cast predominantly base metal
D6792 X	Crown—full-cast noble metal
D6794 X	Crown—titanium
D6930	Recement fixed partial denture
D6980	Fixed partial denture repair, necessitated by restorative material failure

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

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 member by a network dentist.
3. Removable cast-base partial dentures for members under age 12 are excluded from coverage unless specific rationale is provided indicating the necessity for that treatment and is approved by MetLife.
4. Maxillary and mandibular partial dentures—flexible base (*D5225, D5226*) are not covered; however, they will be reimbursed as an alternate benefit for the cost of a maxillary and/or mandibular cast metal partial denture (*D5213, D5214*). The member is responsible for the difference between the dentist's charge for the flexible-base partial denture and the allowance for the cast-metal partial denture.
5. Tissue conditioning is considered integral when performed on the same day as the delivery of a denture or a reline/rebase.

6. Recementation of fixed prosthetics (*D6930*) within six months of placement by the same dentist is considered integral to the original procedure.
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 members under age 16 are not covered unless specific rationale is provided indicating the necessity for such treatment and is approved by MetLife.
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 a covered benefit.
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 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–D5214*), fixed prostheses (*D6210–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 member 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 (*i.e., 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 member 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.

Implant Services

Implant Services Codes *Figure 6.10*

Code	Description of Service
D6010 X	Surgical placement of implant body—endosteal implant
D6013	Surgical placement of mini implant
D6050 X	Surgical placement—transosteal implant
D6052	Semi-precision attachment abutment
D6053 X	Implant/abutment-supported removable denture for completely edentulous arch
D6054 X	Implant/abutment-supported removable denture for partially edentulous arch
D6056 X	Prefabricated abutment—includes modification and placement
D6057 X	Custom fabricated abutment—includes placement
D6058 X	Abutment-supported porcelain/ceramic crown
D6059 X	Abutment-supported porcelain fused to metal crown (*high-noble metal*)
D6060 X	Abutment-supported porcelain fused to metal crown (*predominantly base metal*)
D6061 X	Abutment-supported porcelain fused to metal crown (*noble metal*)
D6062 X	Abutment-supported cast metal crown (*high-noble metal*)
D6063 X	Abutment-supported cast metal crown (*predominantly base metal*)
D6064 X	Abutment-supported cast-metal crown (*noble metal*)
D6065 X	Implant-supported porcelain/ceramic crown
D6066 X	Implant-supported porcelain fused to metal crown (*titanium, titanium alloy, high-noble metal*)
D6067 X	Implant-supported metal crown (*titanium, titanium alloy, high-noble metal*)
D6068 X	Abutment-supported retainer for porcelain/ceramic full partial denture (*FPD*)

Implant Services Codes (continued)

Code	Description of Service
D6069 X	Abutment-supported retainer for porcelain fused to metal FPD (*high-noble metal*)
D6070 X	Abutment-supported retainer for porcelain fused to metal FPD (*predominantly base metal*)
D6071 X	Abutment-supported retainer for porcelain fused to metal FPD (*noble metal*)
D6072 X	Abutment-supported retainer for cast-metal FPD (*high-noble metal*)
D6073 X	Abutment-supported retainer for cast-metal FPD (*predominantly base metal*)
D6074 X	Abutment-supported retainer for cast-metal FPD (*noble metal*)
D6075 X	Implant-supported retainer for ceramic FPD
D6076 X	Implant-supported retainer for porcelain fused to metal FPD (*titanium, titanium alloy, or high noble metal*)
D6077 X	Implant-supported retainer for cast-metal FPD (*titanium, titanium alloy, or high noble metal*)
D6078 X	Implant/abutment-supported fixed denture for completely edentulous arch
D6079 X	Implant/abutment-supported fixed denture for partially edentulous arch
D6090 R	Repair implant-supported prosthesis, by report
D6092	Recement-implant/abutment-supported crown
D6093	Recement-implant/abutment-supported fixed partial denture
D6094 X	Abutment-supported crown—(*titanium*)
D6095 R	Repair implant abutment, by report
D6101 X	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure
D6102 X	Debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure
D6103 X	Bone graft for repair of periimplant defect—not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration

Implant Services Codes (continued)

Code	Description of Service
D6104 X	Bone graft at time of implant placement
D6194 X	Abutment-supported retainer crown for FPD—(*titanium*)

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

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 members under age 14 unless submitted with X-rays and approved by MetLife.
3. Dental implants (*maximum of four total per arch*) are covered for edentulous patients based upon necessity for severe ridge atrophy where a conventional denture would not meet standards of care.
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 MetLife review. The report should describe the problem and how it was repaired.
7. Recementation of an implant/abutment-supported crown (*D6092*) is covered once per six-month period. Recementation 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 considered integral when provided within six months of placement by the same dentist.
9. Semi-precision attachment abutment (*D6052*) includes placement of keeper assembly.

Oral Surgery Services

Oral Surgery Services Codes *Figure 6.11*

Code	Description of Service
D7111	Extraction, coronal remnants—deciduous tooth
D7140	Extraction, erupted tooth or exposed root (*elevation and/or forceps removal*)
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap, if indicated
D7220	Removal of impacted tooth—soft tissue
D7230	Removal of impacted tooth—partially bony
D7240	Removal of impacted tooth—completely bony
D7250	Surgical removal of residual tooth roots (*cutting procedure*)
D7251	Coronectomy—intentional partial tooth removal
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280	Surgical access of an unerupted tooth
D7283	Placement of device to facilitate eruption of impacted tooth
D7285	Biopsy of oral tissue—hard (*bone, tooth*)
D7286	Biopsy of oral tissue—soft (*all others*)
D7290	Surgical repositioning of teeth
D7291 R	Transseptal fiberotomy/supra crestal fiberotomy, by report
D7310	Alveoloplasty in conjunction with extractions—four or more teeth or tooth spaces per quadrant
D7320	Alveoloplasty not in conjunction with extractions—four or more teeth or tooth spaces per quadrant
D7321	Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces per quadrant
D7471	Removal of lateral exostosis—maxilla or mandible

Oral Surgery Services Codes (continued)

Code	Description of Service
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7485	Surgical reduction of osseous tuberosity
D7510	Incision and drainage of abscess—intraoral soft tissue
D7511 R	Incision and drainage of abscess—intraoral soft tissue—complicated (*includes drainage of multiple fascial spaces*)
D7910	Suture of recent small wounds—up to 5 cm
D7911	Complicated suture—up to 5 cm
D7912 R	Complicated suture—greater than 5 cm
D7953	Bone replacement graft for ridge preservation—per site
D7960	Frenulectomy—also known as frenectomy or frenotomy—separate procedure not incidental to another procedure
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity
R = Report required.	

Benefits and Limitations for Oral Surgery Services

1. Fiberotomies 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. Surgical removal of erupted tooth (*D7210*) includes related cutting of gingival and bone, removal of tooth structure, minor smoothing of socket bone and closure.
4. Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed. Coronectomy (*D7251*) will be covered at the same benefit level as other surgical extractions, if eligible.
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 MetLife.
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 when eligible and necessary in relation to the placement of a dental implant and will be covered at the same benefit level as dental implants.
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.

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 *Figure 6.12*

Code	Description of Service
D9110	Palliative (*emergency*) treatment of dental pain—minor procedure

General Anesthesia Services Codes *Figure 6.13*

Code	Description of Service
D9220 R	Deep sedation/general anesthesia—first 30 minutes
D9221 R	Deep sedation/general anesthesia—each additional 15 minutes
R = Report required.	

Intravenous Sedation Services Codes *Figure 6.14*

Code	Description of Service
D9241 R	Intravenous conscious sedation/analgesia—first 30 minutes
D9242 R	Intravenous conscious sedation/analgesia—each additional 15 minutes
R = Report required.	

Consultation Services Codes *Figure 6.15*

Code	Description of Service
D9310	Consultation—diagnostic service provided by dentist or physician other than requesting dentist or physician

Office Visit Services Codes *Figure 6.16*

Code	Description of Service
D9440	Office visit—after regularly scheduled hours

Medication Services Codes *Figure 6.17*

Code	Description of Service
D9610 R	Therapeutic parenteral drug—single administration
D9612 R	Therapeutic parenteral drugs—two or more administrations, different medications
R = Report required.	

Post-Surgical Service Codes *Figure 6.18*

Code	Description of Service
D9930 R	Treatment of complications (*postsurgical*) unusual circumstances, by report
R = Report required.	

Miscellaneous Services Codes *Figure 6.19*

Code	Description of Service
D9940 R	Occlusal guard, by report
D9941	Fabrication of athletic mouth guard
D9974 X	Internal bleaching—per tooth
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 member'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 reported for a non-covered condition, such as 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 MetLife 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.

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.

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, MetLife 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 member 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.
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 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 members' records, charts, or X-rays, or any costs associated with forwarding/mailing copies of members' records, charts, or X-rays.
30. Nitrous oxide.
31. Oral sedation.
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.
6. Extraoral abscesses.
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 and Institutional Benefit

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**.

HIPAA Notice of Privacy Practices for Protected Health Information

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.

Dear MetLife Customer:

This is your Health Information Privacy Notice from Metropolitan Life Insurance Company ("**MetLife**"). **Please read it carefully.** You have received this notice because of your Dental Insurance coverage with us (your "**Coverage**"). MetLife strongly believes in protecting the confidentiality and security of information we collect about you. This notice refers to MetLife by using the terms "us," "we," or "our."

This notice describes how we protect the personal health information we have about you which relates to your MetLife Dental Insurance Coverage ("**Protected Health Information**" or "**PHI**"), and how we may use and disclose this information. PHI includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also describes your rights with respect to the PHI and how you can exercise those rights.

We are required to provide this notice to you by the Health Insurance Portability and Accountability Act ("**HIPAA**"). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please see the privacy notices contained at our website, **www.metlife.com**. You may submit questions to us there or you may write to us directly at MetLife, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902.

NOTICE SUMMARY

The following is a brief summary of the topics covered in this HIPAA notice. Please refer to the full notice below for details.

As allowed by law, we may use and disclose PHI to:

- make, receive, or collect payments;
- conduct health care operations;
- administer benefits by sharing PHI with affiliates and Business Associates;
- assist plan sponsors in administering their plans; and
- inform persons who may be involved in or paying for another's health care.

In addition, we may use or disclose PHI:

- where required by law or for public health activities;
- to avert a serious threat to health or safety;
- for health-related benefits or services;
- for law enforcement or specific government functions;
- when requested as part of a regulatory or legal proceeding; and
- to provide information about deceased persons to coroners, medical examiners, or funeral directors.

You have the right to:

- receive a copy of this notice;
- inspect and copy your PHI, or receive a copy of your PHI;
- amend your PHI if you believe the information is incorrect;
- obtain a list of disclosures we made about you (except for treatment, payment, or health care operations);
- ask us to restrict the information we share for treatment, payment, or health care operations;
- request that we communicate with you in a confidential manner; and

- complain to us or the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

We are required by law to:

- maintain the privacy of PHI;
- provide this notice of our legal duties and privacy practices with respect to PHI;
- notify affected individuals following a breach of unsecured PHI; and
- follow the terms of this notice.

NOTICE DETAILS

We **protect** your PHI from inappropriate use or disclosure. Our employees, and those of companies that help us service your MetLife Dental Insurance Coverage, are required to comply with our requirements that protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to administer our products or services.

We will **not sell or disclose** your PHI to any other company for their use in marketing their products to you. However, as described below, we will use and disclose PHI about you for business purposes relating to your Dental Insurance Coverage.

The main reasons we may **use** and **disclose** your PHI are to evaluate and process any requests for Dental Insurance coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The following describe these and other uses and disclosures.

- **For Payment:** We may use and disclose PHI to pay benefits under your Dental Insurance Coverage. For example, we may review PHI contained in claims to reimburse providers for services rendered. We may also disclose PHI to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose PHI to a health plan or an administrator of an employee welfare benefit plan for various payment-related functions, such as eligibility determination, audit and review, or to assist you with your inquiries or disputes.
- **For Health Care Operations:** We may also use and disclose PHI for our insurance operations. These purposes include evaluating a request for Dental Insurance products or services, administering those products or services, and processing transactions requested by you.
- **To Affiliates and Business Associates:** We may disclose PHI to Affiliates and to business associates outside of the MetLife family of companies if they need to receive PHI to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of PHI. Examples of business associates are: billing companies, data processing companies, companies that provide general administrative services, health information organizations, e-prescribing gateways, or personal health record vendors that provide services to covered entities. PHI may be disclosed to reinsurers for underwriting, audit or claim review reasons. PHI may also be disclosed as part of a potential merger or acquisition involving our business in order that the parties to the transaction may make an informed business decision.
- **To Plan Sponsors:** We may disclose summary health information such as claims history or claims expenses to a plan sponsor to enable it to obtain premium bids from health plans, or to modify, amend or terminate a group health plan. We may also disclose PHI to a plan sponsor to help administer its plan if the plan sponsor agrees to restrict its use and disclosure of PHI in accordance with federal law.
- **To Individuals Involved in Your Care:** We may disclose your PHI to a family member or other individual who is involved in your health care or payment of your health care. For example, we may disclose PHI to a covered family member whom you have authorized to contact us regarding payment of a claim.
- **Where Required by Law or for Public Health Activities:** We disclose PHI when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing PHI to a governmental agency or regulator with health care oversight responsibilities.
- **To Avert a Serious Threat to Health or Safety:** We may disclose PHI to avert a serious threat to someone's health or safety. We may also disclose PHI to federal, state or local agencies engaged in disaster relief, as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

- **For Health-Related Benefits or Services:** We may use your PHI to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of interest to you. However, we will not send marketing communications to you in exchange for financial remuneration from a third party without your authorization.
- **For Law Enforcement or Specific Government Functions:** We may disclose PHI in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose PHI about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **When Requested as Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the PHI requested. We may disclose PHI to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.
- **PHI about Deceased Individuals:** We may release PHI to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death. In addition, we may disclose a deceased's person's PHI to a family member or individual involved in the care or payment for care of the deceased person unless doing so is inconsistent with any prior expressed preference of the deceased person which is known to us.
- **Other Uses of PHI:** Other uses and disclosures of PHI not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose PHI about you, you or your legally authorized representative may revoke that authorization in writing at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Protected Health Information That We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your PHI. Should you have questions about or wish to exercise a specific right, please contact us in writing at the applicable Contact Address listed on the last page.

- **Right to Inspect and Copy Your PHI:** In most cases, you have the right to inspect and obtain a copy of the PHI that we maintain about you. If we maintain the requested PHI electronically, you may ask us to provide you with the PHI in electronic format, if readily producible; or, if not, in a readable electronic form and format agreed to by you and us. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing, electronic media, or other supplies associated with your request. You may also direct us to send the PHI you have requested to another person designated by you, so long as your request is in writing and clearly identifies the designated individual. However, certain types of PHI will not be made available for inspection and copying. This includes collected by us in connection with, or in reasonable anticipation of, any claim or legal proceeding. In very limited circumstances, we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.
- **Right to Amend Your PHI:** If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must specify the reason for your request. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that:
  - is accurate and complete;
  - was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
  - is not part of the PHI kept by or for us; or
  - is not part of the PHI which you would be permitted to inspect and copy.

- **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of your PHI. This list will not include disclosures made for treatment, payment, health care operations, purposes of national security, to law enforcement, to corrections personnel, pursuant to your authorization, or directly to you. To request this list, you must submit your request in writing. Your request must state the time period for which you want to receive a list of disclosures. You may only request an accounting of disclosures for a period of time less than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any cost.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on PHI we use or disclose about you for treatment, payment, or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, **we are not required to agree to it**. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing. In your request, you 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 or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.
- **Contact Addresses:** If you have any questions about a specific individual right or you want to exercise one of your individual rights, please submit your request in writing to the address below which applies to your Dental Insurance Coverage:

  MetLife
  P.O. Box 14183
  Lexington, KY 40512-4587

- **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact MetLife, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions as to how to file a complaint, please contact us at telephone number (212) 578-0299 or at **HIPAAprivacyAmericasUS@metlife.com**.

ADDITIONAL INFORMATION

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for PHI we already have about you, as well as any PHI we receive in the future. The effective date of this notice and any revised or changed notice may be found on the last page, on the bottom right-hand corner of the notice. You will receive a copy of any revised notice from MetLife by mail or by e-mail, if e-mail delivery is offered by MetLife and you agree to such delivery.

Further Information: You may have additional rights under other applicable laws. For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please e-mail us at **HIPAAprivacyAmericasUS@metlife.com** or call us at telephone number (212) 578 0299, or write us at:

MetLife, Americas
U.S. HIPAA Privacy Office
P.O. Box 902
New York, NY 10159-0902

Effective Date: 09232013

Directory of Resources

Online

Visit www.tricare.mil/tdp or
www.metlife.com/tricare.

Find MetLife TDP on Facebook at www.facebook.com.

CONUS

Claim Submissions

MetLife TRICARE Dental Program
P.O. Box 14181
Lexington, KY 40512

Fax: 1-855-763-1333

Customer Service

1-855-MET-TDP1 (1-855-638-8371) (*toll-free*)
Sunday 6:00 p.m.–Friday 10:00 p.m. (EST), except holidays

MetLife TDD/TTY service for the hearing impaired:
1-855-MET-TDP3 (1-855-638-8373) (*toll-free*)

OCONUS

Claim Submissions

MetLife TRICARE Dental Program
P.O. Box 14182
Lexington, KY 40512

Fax: 1-855-763-1334
E-mail: OCONUSdentalclaims@metlife.com

Customer Service

1-855-MET-TDP2 (1-855-638-8372) (*toll-free*)
Representatives are available to assist beneficiaries in English, German, Italian, Japanese, Korean, and Spanish, Sunday 6:00 p.m.–Friday 10:00 p.m. (EST), except holidays

MetLife TDD/TTY service for the hearing impaired:
1-855-MET-TDP3 (1-855-638-8373) (*toll-free*)

Quality of Care

Inquiries

MetLife
TRICARE Dental Program
Quality of Care—Grievances
P.O. Box 14184
Lexington, KY 40512
Fax: 1-855-763-1336

Enrollment and Billing Services

Enrollment and Billing Forms, Correspondence

MetLife TRICARE Dental Program
Enrollment and Billing Services
P.O. Box 14185
Lexington, KY 40512

CONUS: 1-855-MET-TDP1 (1-855-638-8371) (*toll-free*)

OCONUS: 1-855-MET-TDP2 (1-855-638-8372) (*toll-free*)

MetLife TDD/TTY service for the hearing impaired:
1-855-MET-TDP3 (1-855-638-8373) (*toll-free*)

Billing Payments

MetLife
P.O. Box 13740
Philadelphia, PA 19101

Fraud and Abuse Issues

Inquiries

MetLife
Special Investigations Unit—TRICARE
5950 Airport Road
Oriskany, NY 13424

Fraud Hotline

1-800-462-6565 (*toll-free*)

Other TRICARE-Related Listings

Defense Manpower Data Center Support Office

400 Gigling Road
Seaside, CA 93955-6771

Verify Eligibility: 1-800-538-9552

Dental Provider Listings

Visit www.metlife.com/tricare
or contact customer service.

An Important Note About TRICARE Dental Program Changes

At the time of publication, 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 your TRICARE Dental Program contractor. 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.

February 2014

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