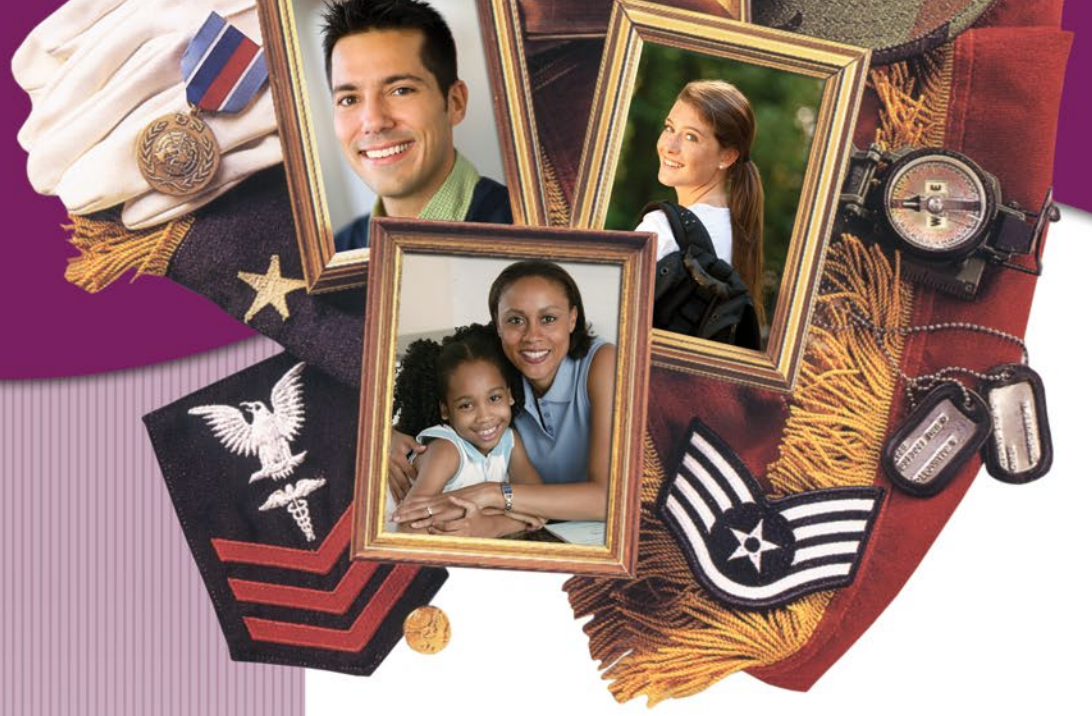


DENTAL

TRICARE®
Dental Program Benefit Booklet

For active duty family members and National Guard and Reserve members and their families

TRICARE®

TRICARE Dental Program (TDP) Contact Information and Resources

MetLife Online:

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

https://mybenefits.metlife.com/tricare

Beneficiary Web Enrollment Portal:

- *Enrollment*
- *Termination of enrollment*
- *Add/remove beneficiary*
- *View premium rates*
- *Request TDP identification card*

www.tricare.mil/bwe

MetLife by Phone:*

- *General inquires*
- *Claims*
- *Billing assistance*
- *Enrollment*
- *Termination of enrollment*
- *Add/remove beneficiary*
- *Request TDP benefit materials*

CONUS

1-855-MET-TDP1 (1-855-638-8371)

OCONUS

1-855-MET-TDP2 (1-855-638-8372)

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

Paper Enrollments:

- *Enroll by mail*
- *Submit power of attorney copy* (if required)

MetLife TRICARE Dental Program
P.O. Box 14185
Lexington, KY 40512

Claim Submissions:

CONUS

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

Fax: 1-855-763-1333

OCONUS

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

Fax: 1-855-763-1334

E-mail: OCONUSdentalclaims@metlife.com

* *MetLife representatives can be reached by phone 24 hours a day from Sunday at 6:00 p.m. (EST) through Friday at 10:00 p.m. (EST), except holidays. Customer service representatives are available to assist beneficiaries in the following languages: English, German, Italian, Japanese, Korean, and Spanish.*

An Important Note about TRICARE Dental Program Information

This *TRICARE Dental Program Benefit Booklet* will help you learn about your TDP benefits and services. At the time of printing, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. For the most recent information, contact MetLife at 1-855-638-8371 (CONUS) or 1-855-638-8372 (OCONUS) or visit them online at https://mybenefits.metlife.com/tricare. 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.

Table of Contents

See the inside back cover of this booklet for "TRICARE Expectations for Beneficiaries."

TRICARE Dental Program

The TRICARE Dental Program (TDP), administered by MetLife, is a worldwide dental care plan offered to eligible beneficiaries by the Department of Defense through the TRICARE Management Activity. The TDP makes it cost effective and convenient to care for your oral health.

MetLife is committed to providing you with beneficiary-centered administration of the TDP to help you and your loved ones enjoy good oral health. Please refer to the contact information on the inside front cover any time you need assistance.

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

Eligibility and Enrollment

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

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

Individuals Eligible to Enroll in the TDP

Family members of active duty service members (ADSMs) and National Guard and Reserve family members:

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

National Guard and Reserve service members:

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

Verification of Eligibility

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

1. *Online* at **www.dmdc.osd.mil/appj/address/index.jsp**. This method is a quick and easy way to update address and contact information.
2. *In Person* by visiting a local personnel office that has a uniformed services identification (ID) card-issuing facility. To locate the nearest facility, visit **www.dmdc.osd.mil/rsl**. Please call ahead for hours of operation and for detailed instructions.
3. *Call* the Defense Manpower Data Center Support Office at **1-800-538-9552**. Hours of operation are Monday–Friday, 5:00 a.m.–5:00 p.m. (PT), except on federal holidays.
4. *Fax* changes to DEERS at **1-831-655-8317**. The sponsor's Department of Defense

Benefits Number and/or Social Security number must be included with the faxed documents.

5. *Mail* changes to:

   Defense Manpower Data Center
   Support Office
   Attn: COA
   400 Gigling Road
   Seaside, CA 93955-6771

Individuals Who Are Not Eligible for TDP Coverage

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

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

Enrollment Options

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

Single Enrollment

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

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

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

Family Enrollment

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

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

- Children under age 4 may be voluntarily enrolled at any time. However, these children can be excluded from enrollment at the discretion of the sponsor if there is only one enrolled beneficiary in the family age 4 or older.
- If a sponsor has family members living in two or more locations (*e.g., in the case of children who are attending college away from home or living with a custodial parent/former spouse*), they may choose to enroll the family members living in one location or may elect to enroll eligible family members residing in multiple locations. The sponsor must identify those family members residing in separate locations and report the information to MetLife.
- For ADFM dental care that requires a hospital or special treatment environment (*due to a medical condition, physical handicap, or behavioral health condition*), the family member may be excluded from TDP enrollment and may continue to receive care from a military treatment facility (MTF). However, the sponsor must provide MetLife with documentation, such as a signed letter or memorandum from the provider or administrator, attesting to this requirement. Prior to receipt of the services, the sponsor must also provide documentation with any request to terminate enrollment.
- National Guard and Reserve sponsors must enroll independently of their family members. Also, National Guard and Reserve sponsors can enroll their family members and not themselves. If sponsors choose to enroll themselves in addition to the family member(s), there will be separate premium bills for each contract—one for the sponsor and one for the family member(s).

Note: Beneficiaries cannot be enrolled under two TDP contracts. Two sponsors cannot enroll the same family member(s). Additionally, if both the husband and wife are ADSMs, both sponsors cannot enroll each other as a family member.

If one is a National Guard or Reserve sponsor (*not activated for more than 30 consecutive days*), he or she can be enrolled as a family member under the other sponsor.

Automatic Enrollment of Children at Age 4

If there is an existing family plan in effect, children will be automatically enrolled on the first day of the month following the month in which they reach age 4. Also, at the sponsor's discretion, children can be enrolled before they are age 4. If the existing plan is for a single family member only, the premium will change from the single plan rate to the family plan rate.

Please remember dental care is not covered by the TDP until the coverage effective date noted on the TDP ID card. If you have not received a TDP ID card, please reference the inside front cover of this booklet for contact information and details.

Enrollment Period

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

Sponsors who fail to pay premiums will be locked out for 12 months before they can request reenrollment.

Enrolling in the TDP

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

- **Online**
  - Visit **www.tricare.mil/bwe** to access the BWE portal
- **Telephone**
  - CONUS: **1-855-MET-TDP1 (1-855-638-8371)**
  - OCONUS: **1-855-MET-TDP2 (1-855-638-8372)**
  - TDD/TTY: **1-855-MET-TDP3 (1-855-638-8373)**
- **Mail**
  - The *TDP Enrollment Authorization* document can be downloaded from the BWE link at **www.tricare.mil/bwe**.
  - Mail the completed *TDP Enrollment Authorization* document along with the initial premium payment (*check, money order, or credit card*) to MetLife at:

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

Premium Payment

- **Initial payment**—For the first month of coverage, your initial payment can be made by credit card for enrollments completed online, by phone, or by mail. You have the option of paying by check or money order for enrollments done by mail. However, most members will find online enrollment to be the fastest and most convenient method.
- **Ongoing payments**—Payroll allotment is the required method for ongoing payment for enrollments associated with an ADSM. However, ongoing payments for enrollments associated with a National Guard or Reserve sponsor can be made with a credit card, electronic funds transfer, or payroll allotment.

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

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

Enrollment for TDP coverage will be confirmed with the issuance of TDP ID cards. Please remember the TDP does not cover dental care until the enrollment effective date noted on the card. If you have not yet received your TDP ID card and are seeking care, please reference the inside front cover of this booklet for contact information and details.

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

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

Effective Date of Coverage

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

For example: If the initial premium payment is received by May 20, coverage will be effective June 1. If the request for enrollment and initial premium payment are received May 21 through June 20, coverage will be effective July 1. Enrollment is processed according to the date received by MetLife (*not the postmark date*).

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

Evidence of Coverage

Each enrolled beneficiary will receive a personalized TDP ID card confirming enrollment. This card should be presented at each dental office visit. Replacement cards can be requested by accessing the BWE portal at **www.tricare.mil/bwe**. MetLife highly recommends that your dentist obtain current coverage information from MetLife before rendering services.

Events Affecting Your Enrollment

There are a variety of reasons for adding a family member to the TDP such as:

- Marriage
- Birth
- Adoption (*pre-adoptive and finalized adoption as reflected in DEERS*)
- Stepchild or court-ordered ward newly eligible for TDP
- Child added before turning age 4

There are also reasons for deleting a family member from the TDP such as:

- Death
- Divorce—there is no former spouse coverage for this program
- Loss of child's eligibility when he or she marries or turns 21 or 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50 percent of the financial support

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

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

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

Note: Most members will find going online to be the fastest and most convenient method. However, when submitting by mail, the *TDP Enrollment Authorization* document can be downloaded from the BWE Web site, accessible at **www.tricare.mil/bwe**. Please print, complete, and mail the *TDP Enrollment Authorization* document to MetLife. Enrollment/change forms are also available by visiting the local uniformed services DTF or TRICARE Service Center.

If the sponsor is not available to complete an enrollment or terminate an enrollment, an individual with an appropriate POA can do so on their behalf. A copy of the valid POA must be on file with MetLife. To put a POA on file with MetLife, please reference the inside front cover of this booklet for contact information and details.

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

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

For example, if your termination of enrollment request is received by June 20, the cancellation will take effect on July 1. If your cancellation request is received on June 21 through July 20, the termination of enrollment will take effect on August 1. If the request is made by mail, it will be processed according to the date of receipt (*not postmark*). Please remember, you are responsible for all monthly premiums until coverage is canceled.

Acceptable Reasons to Terminate Enrollment Before Completing the Initial 12-Month Enrollment Period

Termination of Enrollment Before Completing the Initial 12-Month Enrollment Period *Figure 2.1*

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

Enrollment Change/Termination of Enrollment Scenarios

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

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

Enrollment Change/Termination of Enrollment Scenarios *Figure 2.2*

Scenario[1]	Change in TRICARE Dental Program (TDP) Enrollment
Two active duty service members (ADSMs) are married with TDP-enrolled children. The parent listed as the sponsor leaves active duty service.	• TDP-enrolled children's enrollment is terminated as of 11:59 p.m. on the last day of the month in which the parent listed as the sponsor leaves active duty service. If the sponsor leaves the service on the first day of the month, the last day of coverage is the last day of the previous month. • Remaining ADSM may reenroll family.
An ADSM transfers from active duty to the Selected Reserve of the Ready Reserve or Individual Ready Reserve (IRR) (*special mobilization category*).	• TDP-enrolled family members' enrollment is terminated as of 11:59 p.m. on the last day of the month in which the sponsor changes status. If the sponsor changes status on the first day of the month, the last day of coverage is the last day of the previous month. • Sponsor may enroll self and/or reenroll family members.

1. For all of the scenarios in which the coverage is canceled and reenrollment is not automatic, the sponsor must reenroll within 30 days of cancellation to prevent a lapse in coverage and continue the original 12-month initial enrollment period.

Enrollment Change/Termination of Enrollment Scenarios (continued) *Figure 2.2*

Scenario[1]	Change in TRICARE Dental Program (TDP) Enrollment
A National Guard or Reserve member (*non-contingency related*) transfers to the Selected Reserve of the Ready Reserve or IRR (*special mobilization category*).	• TDP-enrolled family members' enrollment is terminated as of 11:59 p.m. on the last day of the month in which the sponsor changes status. If the sponsor changes status on the first day of the month, the last day of coverage is the last day of the previous month. • Family members are automatically reenrolled in the TDP as Selected Reserve/IRR family members. Appropriate premium change will apply.
Sponsor transfers to another service branch.	• TDP-enrolled sponsor and/or family members' enrollment is terminated as of 11:59 p.m. on the last day of the month in which the sponsor transfers to another branch. If the sponsor transfers branches on the first day of the month, the last day of coverage is the last day of the previous month. • Sponsor may reenroll self and/or family members.
A Selected Reserve of the Ready Reserve or IRR (*special mobilization category*) sponsor changes status to IRR (*other than special mobilization category*).	• TDP-enrolled sponsor and/or family members' enrollment is terminated as of 11:59 p.m. on the last day of the month in which the sponsor changes status. If the sponsor changes status on the first day of the month, the last day of coverage is the last day of the previous month. • Sponsor and/or family members are automatically reenrolled into the appropriate plan, but may choose to terminate enrollment from the TDP without completing the 12-month lock-in. Premium changes may apply.
A Selected Reserve of the Ready Reserve or IRR sponsor and/or family have been enrolled in the TDP for more than 30 days and sponsor called to active duty for more than 30 consecutive days and has enrolled him or herself and family in TDP more than 30 days prior to start of the active duty orders.	**Sponsor:** • TDP-enrolled sponsor enrollment is terminated effective on the first day of the active duty orders. • Upon deactivation, coverage will be automatically reinstated the day following status change and sponsor is responsible for completing the remaining months on his or her initial 12-month lock-in period. **Family Members:** • TDP-enrolled family members' enrollment is terminated as of 11:59 p.m. on the last day of the month in which the sponsor changes status. If the sponsor changes status on the first day of the month, the last day of coverage is the last day of the previous month. • Family members are automatically reenrolled in the program as active duty family members with the lower premium rate. • Coverage continues under the existing 12-month lock-in period. • Premium rate returns to the appropriate Selected Reserve or IRR rate on the first of the month following the sponsor's deactivation.

1. For all of the scenarios in which the coverage is canceled and reenrollment is not automatic, the sponsor must reenroll within 30 days of cancellation to prevent a lapse in coverage and continue the original 12-month initial enrollment period.

End-of-Eligibility Scenarios

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

End-of-Eligibility Scenarios *Figure 2.3*

Scenario	When TRICARE Dental Program (TDP) Coverage Ends
Sponsor retires or separates from active duty service.	The last day of coverage is the last day of the month in which the sponsor retires or separates. However, if the sponsor's retirement or separation is on the first day of the month, the last day of coverage is the last day of the previous month. For example: If the sponsor retires on May 1, the last day of coverage is April 30.[1]
Unmarried child turns age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50% of the financial support*).	The child loses eligibility as of 11:59 p.m. on the last day of the month in which the age limit is reached.
Spouse and sponsor divorce.	The spouse loses all eligibility based on his or her former marital status as of 11:59 p.m. on the last day of the month in which the divorce becomes final.

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

TDP Survivor Benefit

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

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

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

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

- Surviving spouse for up to three years from the sponsor's date of death
- Surviving children until age 21, or 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provided over 50 percent of the financial support at the time of the sponsor's death

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

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

National Guard and Reserve Important Information

Dental Readiness Assessment for National Guard and Reserve

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

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

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

Sponsor's Changing Status

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

National Guard and Reserve Sponsor Coverage

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

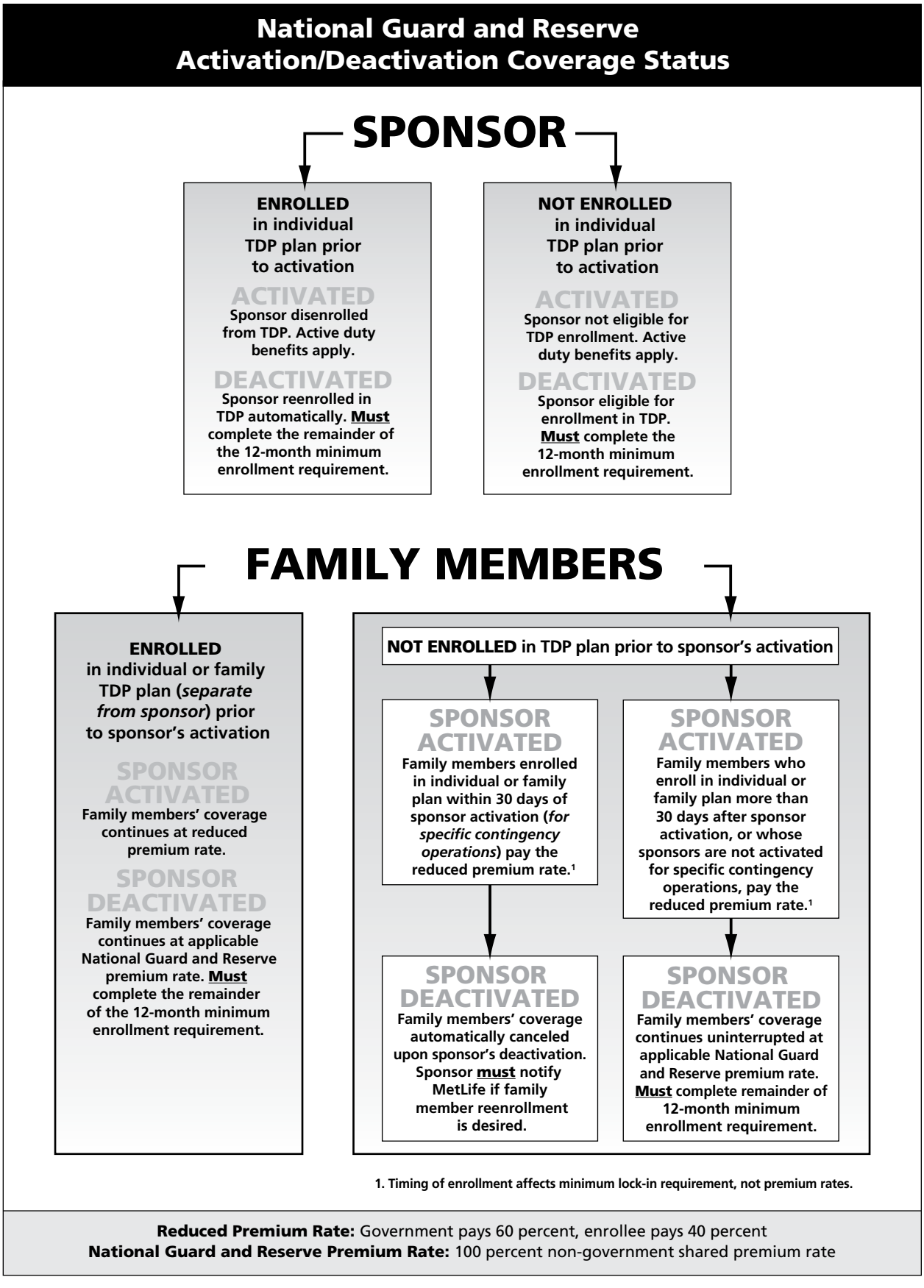
A National Guard or Reserve sponsor is not considered part of a family plan and can be enrolled even if the family is not enrolled. The sponsor also has a separate monthly premium.

National Guard and Reserve Family-Member Coverage

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

The following coverage flowchart demonstrates how TDP coverage changes when a National Guard or Reserve sponsor's status changes.

National Guard and Reserve Activation/Deactivation Coverage Status *Figure 3.1*



Choosing a Dentist

CONUS Dentists

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

Participating Dentists

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

- Accept MetLife's negotiated fee as payment in full, charging the family member only the applicable cost-share percentage. The negotiated fee is often lower than the normal rate charged by dentists in the area and, therefore, saves you money.
- Invoice MetLife directly for its share of the bill, so you do not have to pay the dentist directly and await reimbursement.*
- Complete the claim submission document for you and submit it to MetLife on your behalf.
- Participate in MetLife's quality-assurance programs.
- Provide any information needed by MetLife to make coverage and payment determinations.
- Complete the *Department of Defense Active Duty/Reserve Forces Dental Examination* form (DD Form 2813) for National Guard and Reserve members.

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

To locate a PDP dentist, please reference the inside front cover of this booklet for contact information and details. It is important to remember to check with the dentist to make sure he or she still participates in the PDP.

Timely Appointments

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

Non-network Dentists

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

Non-network dentists are not required to accept direct payment from MetLife. To send payment directly to a non-network dentist, you must sign an assignment of benefits statement on the claim submission document. This allows MetLife to send payment to the non-network dentist and to notify the member with a dental explanation of benefits. If the assignment of benefits provision is not signed, MetLife's payment will be sent to the member, and he or she will be responsible for paying the dentist.

Ask your dentist if he or she is a participating dentist with MetLife. If the dentist is not participating in MetLife's PDP network, you may continue to receive care, but be aware that you may incur higher out-of-pocket costs.

If your dentist is interested in becoming a MetLife PDP dentist, ask him or her to call MetLife's Dental Customer Service Department at **1-877-MET-DDS9 (1-877-638-3379)** or visit **www.metdental.com** to obtain an application packet.

OCONUS Dentists

As a convenience to you, a directory of TRICARE OCONUS Preferred Dentists (TOPDs), including orthodontists, is available on the MetLife Web site at **https://mybenefits.metlife.com/tricare**. TOPDs have agreed to the following:

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

Prior to initiating treatment for a dental procedure that requires a cost-share or where the total cost of the procedure will exceed U.S. $1,300, it is recommended that you have your dentist submit a pre-determination request to MetLife.

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

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

Note: For any orthodontic service, OCONUS members will need to obtain a *Non-Availability and Referral Form (NARF)* from their TRICARE Area Office, overseas uniformed services dental treatment facility, or designated OCONUS points of contact before any orthodontic treatment can begin, and submit it with the claim submission document.

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 for patients under age 19 when involving posterior teeth. They are covered at a 20 percent cost-share for patients under age 19 when replacing anterior teeth only. 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 (*including bitewings*)
D0220[1]	Intraoral—periapical first film
D0230[1]	Intraoral—periapical—each additional film
D0240[1]	Intraoral—occlusal film
D0250	Extraoral—first film
D0260	Extraoral—each additional film
D0270[1]	Bitewing—single film
D0272[1]	Bitewings—two films
D0273[1]	Bitewings—three films
D0274[1]	Bitewings—four films
D0290	Posterior-anterior or lateral skull and facial bone survey film
D0330[1]	Panoramic film
D0340	Cephalometric film
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 film or full series of X-rays for a patient under age 5.

Benefits and Limitations for Diagnostic Services

1. Three oral evaluations (*D0120, D0150, or D0180*) are covered in a consecutive 12-month period. Only two of these oral evaluations may be from the same office. A third oral evaluation is covered only if it is rendered by a different office. A comprehensive periodontal evaluation will be considered integral if provided on the same date of service, by the same dentist, as any other oral evaluation.
2. Comprehensive evaluations (*D0150*) are only eligible:
   - For new patients
   - For patients who have not had an oral evaluation within the previous 36 months from the same office
   - On an exception basis, by report, for patients who have had a significant change in health conditions or other unusual circumstances
3. Three oral evaluations (*D0145*) for patients under age 3 are covered in a consecutive 12-month period. Only two of these oral evaluations (*D0145*) may be from the same office. A third oral evaluation (*D0145*) is covered only if it is rendered by a different office. However, the total number of evaluations (*D0145, D0150, D0120*) for a patient under age 3 in a consecutive 12-month period cannot exceed a total of three evaluations.
4. One comprehensive periodontal evaluation (*D0180*) will be allowed per patient per consecutive 12-month period per office. A comprehensive periodontal evaluation will be considered integral if provided on the same date of service by the same dentist as any other oral evaluation.
5. Limited oral evaluation, problem-focused (*D0140*), is eligible once per patient per dentist in a consecutive 12-month period in conjunction with consultations (*D9310*)—only one of these services is eligible within a consecutive 12-month period. A limited oral evaluation will be considered integral when provided on the same date of service, by the same dentist, as any other oral evaluation.
6. Reevaluations are considered integral procedures.
7. Detailed and extensive oral evaluations, problem-focused (*D0160*), are only payable by report upon review and are limited to once per patient per dentist, per the life of the contract. They will not be paid if related to

non-covered medical, dental, or adjunctive dental procedures.

8. X-rays that are not of diagnostic quality are not covered and may not be charged to the patient when provided by a 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 films, are considered integral and should not be billed separately.
20. X-rays are not covered when performed in conjunction with the diagnosis or treatment of temporomandibular joint dysfunction (TMD).
21. Posterior-anterior or lateral skull and facial bone survey films (*D0290*) and cephalometric films (*D0340*) are each covered once per 12-month period. They are not covered for the diagnosis or treatment of TMD.
22. Cephalometric films are covered for patients under age 23.
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

Note: A 20 percent cost-share will be applied to space maintainers (*D1510, D1515, D1520, and D1525*) when replacing incisors only.

Preventive Services Codes ***Figure 6.2***

Code	Description of Service
D1110[1]	Prophylaxis—adult
D1120[1]	Prophylaxis—child
D1203[1]	Topical application of fluoride (*prophylaxis not included*)—child
D1204[1]	Topical application of fluoride (*prophylaxis not included*)—adult
D1206[1]	Topical fluoride varnish; therapeutic application for moderate-to-high caries risk patients
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

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 for patients under age 19 when involving posterior teeth. They are covered at a 20 percent cost-share for patients under age 19 when replacing anterior teeth only.
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 or D6973*).
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
D2950 X	Core buildup, including pins
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 R	Crown repair, by report

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*) can be considered for benefits only when there is insufficient retention for a crown. A buildup should not be reported when the procedure only involves a filler used to eliminate undercuts, box forms, or concave irregularities in the 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.

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
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

Endodontic Services Codes (continued)

Code	Description of Service
D3348	Retreatment of previous root canal therapy—molar
D3351	Apexification/recalcification/pulpal regeneration—initial visit (*e.g., apical closure/calcific repair of perforations, root resorption, pulp space disinfection*)
D3352	Apexification/recalcification/pulpal regeneration—interim medication replacement (*e.g., apical closure/calcific repair of perforations, root resorption, pulpal space disinfection*)
D3353	Apexification/recalcification—final visit (*includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption*)
D3354	Pulpal regeneration—(*completion of regenerative treatment in an immature permanent tooth with a necrotic pulp*); does not include final restoration
D3410	Apicoectomy/periradicular surgery—anterior
D3421	Apicoectomy/periradicular surgery—bicuspid (*first root*)
D3425	Apicoectomy/periradicular surgery—molar (*first root*)
D3426	Apicoectomy/periradicular surgery (*each additional root*)
D3430	Retrograde filling—per root
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 where the intra-canal medication is replaced with new medication and necessary radiographs. There may be several of these visits.
20. The apexification final visit (*D3353*) includes the last phase of complete root canal therapy. Root canal therapy reported in addition to apexification treatment is not a separately reimbursable procedure.
21. Pulpal regeneration (*D3354*) includes removal of intra-canal medication and procedures necessary to regenerate continued root development and necessary radiographs. This procedure includes placement of a seal at the coronal portion of the root canal system. Conventional root canal treatment is not performed. Pulpal regeneration (*D3354*) will be covered at the same benefit level as (*D3351, D3352, and D3353*).

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
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
D4271 C	Free soft-tissue graft procedure (*including donor site surgery*)
D4275 C	Soft-tissue allograft
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

Periodontal Services Codes (continued)

Code	Description of Service
D4910	Periodontal maintenance
D4920	Unscheduled dressing change (*by someone other than treating dentist*)
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 soft-tissue graft (*D4271*) 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 (*D4271*). 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, D4264*) are only eligible when provided to treat teeth having periodontal defects. The tooth/teeth must be present in order to report these two procedure codes. They are not eligible when provided for other reasons such as filling in an extraction site or a defect resulting from an apicoectomy or cyst removal.
9. 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.
10. 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.
11. Osseous surgery is not covered when provided within 24 months of osseous surgery in the same area of the mouth.
12. Osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same dentist, and in the same area of the mouth is considered an integral procedure.
13. One crown lengthening per tooth, per lifetime, is covered.
14. Guided tissue regeneration is only covered when provided to treat specific types of periodontal defects (*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.
15. 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.
16. Periodontal scaling and root planing provided within 24 months of periodontal scaling and root planing or periodontal surgical procedures in the same area of the mouth is not covered.
17. 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.
18. 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.
19. 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.
20. 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.

21. Periodontal maintenance is generally covered when performed following active periodontal treatment.
22. Periodontal maintenance provided on the same day as periodontal scaling and root planing is considered integral.
23. 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.
24. 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.
25. Procedures related to the placement of an implant (*e.g., bone recontouring and excision of gingival tissue*) are not covered.
26. Surgical revision procedure (*D4268*) is considered integral to all other periodontal procedures.
27. Full-mouth debridement to enable comprehensive evaluation and diagnosis (*D4355*) is covered once within a consecutive 24-month period.
28. 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*)

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
D6601 X	Inlay—porcelain/ceramic, three or more surfaces
D6602 X	Inlay—cast high-noble metal, two surfaces

Prosthodontics, Fixed Services Codes (continued)

Code	Description of Service
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
D6791 X	Crown—full-cast predominantly base metal
D6792 X	Crown—full-cast noble metal
D6794 X	Crown—titanium

Prosthodontics, Fixed Services Codes (continued)

Code	Description of Service
D6930	Recement fixed partial denture
D6970 X	Post and core in addition to fixed partial denture retainer, indirectly fabricated
D6972 X	Prefabricated post and core in addition to fixed partial denture retainer
D6973 X	Core buildup for retainer, including pins
D6980 R	Fixed partial denture repair, by report

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. Additional posts (*D6976, D6977*) are considered integral to the associated restorative procedure.
17. Precision attachments, personalization, precious-metal bases, and other specialized techniques are not covered.
18. 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.

19. 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.
20. 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.
21. 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
D6050 X	Surgical placement—transosteal implant

Implant Services Codes (continued)

Code	Description of Service
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 placement
D6057 X	Custom 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*)
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*)

Implant Services Codes (continued)

Code	Description of Service
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
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.

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

Oral Surgery Services Codes (continued)

Code	Description of Service
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
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 grafts provided for ridge preservation (*socket grafts*)
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**.

Orthodontic Services

The TRICARE Dental Program (TDP) covers orthodontic services. This section will highlight eligibility requirements, covered services, maximums, and how to access care.

Eligibility

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

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

Covered Services

Diagnostic Cast Services Codes *Figure 7.1*

Code	Description of Service
D0470	Diagnostic casts

Note: Diagnostic casts are payable at 50 percent of MetLife's allowance, once per orthodontic treatment plan, when provided with covered orthodontic procedures. Payment for diagnostic casts applies toward the annual maximum. For command sponsored members in the OCONUS service area, there is no cost-share for this service.

Covered Services Codes *Figure 7.2*

Code	Description of Service
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition

Covered Services Codes (continued)

Code	Description of Service
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult dentition
D8050	Interceptive orthodontic treatment of the primary dentition
D8060	Interceptive orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
D8210	Removable appliance therapy
D8220	Fixed-appliance therapy
D8670	Periodic orthodontic treatment visit (*as part of contract*)
D8680	Orthodontic retention (*removal of appliances, construction, and placement of retainer[s]*)
D8690 R	Orthodontic treatment (*alternative billing to a contract fee*)
R = Report required.	

Benefits and Limitations for Orthodontic Services

1. Payment for diagnostic services performed in conjunction with orthodontics is applied to the patient's annual maximum, except as identified in the footnote under Figure 6.1 in Section 6 of this booklet.
2. Orthodontic consultations will be processed as comprehensive or periodic evaluations and are subject to the same time limitations. See "Diagnostic Services" in Section 6 of this booklet.
3. Orthodontic treatment is available for family members (*non-spouse*) up to, but not including, age 21 (*or up to age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50 percent of the financial support*).

4. Orthodontic treatment is available for spouses and National Guard and Reserve sponsors up to, but not including, age 23. Coverage is effective until the end of the month in which the enrollee reaches the applicable age limit.
5. Initial payment for orthodontic services will not be made until a banding date has been submitted to MetLife.
6. All retention and case-finishing procedures are integral to the total case fee.
7. Observations and adjustments are integral to the payment for retention appliances.
8. Repair of damaged orthodontic appliances is not covered.
9. Recementation of an orthodontic appliance by the same dentist who placed the appliance and/or who is responsible for the ongoing care of the patient is not covered. However, recementation by a different dentist will be considered for payment as palliative emergency treatment.
10. The rebonding and/or repair of a fixed retainer (*D8693*) is not a covered benefit.
11. The replacement of a lost or missing appliance is not a covered benefit.
12. Myofunctional therapy is integral to orthodontic treatment and is not payable as a separate benefit.
13. Orthodontic treatment (*alternative billing to a contract fee*) will be reviewed for individual consideration with any allowance being applied to the orthodontic lifetime maximum (OLM). It is only payable for services rendered by a dentist other than the dentist rendering complete orthodontic treatment.
14. Periodic orthodontic treatment visits (*as part of contract*) are considered an integral part of a complete orthodontic treatment plan and are not reimbursable as a separate service. MetLife will use the corresponding appropriate code based on the treatment when making periodic payments as part of the complete treatment plan payment.
15. It is the dentist's and the member's responsibility to notify MetLife if orthodontic treatment is discontinued or completed sooner than anticipated.

Orthodontic Lifetime Maximum

Each orthodontic payment is conditional depending on the patient's actual remaining OLM balance. If the patient's OLM has been met before the payment schedule has been completed, further payments are discontinued. Payment for diagnostic services performed in conjunction with orthodontics is applied to the patient's $1,300 annual maximum. The maximum lifetime benefit for orthodontic services under the TDP is $1,750 per member.

Orthodontic Treatment in the CONUS Service Area

Orthodontic Cost-Share (*CONUS*)

The orthodontic services listed as covered procedures are payable at 50 percent of the allowed fee or MetLife's remaining amount of the aggregate maximum benefit for orthodontic treatment (*for all dental expense periods*), whichever is lower, subject to a lifetime maximum payment per member of $1,750. The OLM in effect when the orthodontic treatment started will be the OLM in effect for the entire course of treatment. However, in the case of those beneficiaries who had previously

accumulated all or part of the $1,500 orthodontic services lifetime maximum applicable under the predecessor contract, additional coverage for orthodontic services shall be made available up to the cumulative total of $1,750. The beneficiary must be in active orthodontic treatment to receive the additional benefit. The patient is responsible for the 50 percent fixed cost-share until the benefit is exhausted or until the OLM is reached. When the OLM is reached, the patient is responsible for the remainder of the fee (*either MetLife's allowance for a participating dentist or the billed amount for a non-network dentist*).

Orthodontic Payments (*CONUS*)

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

- At initial banding, a payment of 25 percent of the total amount payable under the program is issued.
- The remaining 75 percent of the payable amount is paid in quarterly installments, based on the estimated length of treatment, not to exceed the OLM.
- If the length of treatment is six months or less, MetLife's payment will be made in one lump sum. If the length of treatment is more than six months, but MetLife's liability is $500 or less, payment will be made in one lump sum. If the length of treatment is more than six months and more than $500, payments will be issued on a quarterly basis.
- The patient must be enrolled in the TDP during each month that payment is made.
- The quarterly payments are calculated and processed automatically at the end of the three-month period.

Orthodontic Payment Example (*CONUS*)

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

Payment Calculations for Eligible Treatment (CONUS)

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

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

MetLife payment = $1,750	$4,000 x 50% cost-share = $2,000 (*subject to $1,750 orthodontic lifetime maximum [OLM]*)
Beneficiary out-of-pocket cost = $2,250	$4,000 x 50% cost-share = $2,000 + $250 (*amount remaining after application of OLM*)
MetLife's installments to the dentist would be made as follows:	
Payment at initial banding	$1,750 x 25% = $437.50
8 quarterly payments of $164 each	$1,312.50 ÷ 8 = $164.06

Orthodontic Treatment in the OCONUS Service Area

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

OCONUS Orthodontic Services

For orthodontic services, beneficiaries in all OCONUS locations are required to have a *Non-Availability and Referral Form (NARF)* issued by the TRICARE Area Office (TAO), overseas uniformed services dental treatment facility (ODTF), or designated OCONUS points of contact (POCs). Any licensed and authorized orthodontist can provide orthodontic care. For your convenience, the TDP maintains a TOPD list that can be accessed at **https://mybenefits.metlife.com/tricare.**

Orthodontic Cost-Share (*OCONUS*)

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

- Member pays cost-share based on the lesser of dentist's actual charge or MetLife's allowed fee.
- MetLife pays the remaining appropriate billed charges, but for command sponsored members, MetLife is reimbursed by the government for billed charges in excess of the allowed fee.

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

Orthodontic Payments (*OCONUS*)

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

If a member exceeds the age limitation (*described earlier*) during the course of orthodontic treatment, MetLife's payment will be calculated based on the months of actual eligibility. All charges incurred after the loss of eligibility will be the member's responsibility.

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

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

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

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

MetLife payment = $3,000[1]	$4,000 x 50% = $2,000 plus $1,000 (*amount of dentist actual fee in excess of allowed fee*)
Beneficiary out-of-pocket cost = $2,000	$4,000 x 50% = $2,000

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

OCONUS Referral Procedures for Orthodontic Services

OCONUS Locations

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

After the initial exam is completed, the initial *NARF*, the claim submission document, and the provider's bill for the initial exam and treatment plan should be sent to MetLife for payment.

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

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

After receiving the predetermination, the sponsor may submit the second *NARF* (*approving the comprehensive orthodontic treatment*), the claim submission document, and the dentist's bill for full orthodontic treatment to MetLife for payment. TDP claim submission documents are available at **https://mybenefits.metlife.com/tricare**.

Transferring Orthodontists

CONUS to CONUS

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

CONUS to OCONUS

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

OCONUS to CONUS

Orthodontic care that was provided OCONUS will typically be paid in a lump sum. If total payments made by the TDP met or exceeded the maximum, that member will be ineligible for additional claim payments by the TDP for services subsequently received in CONUS locations.

TRICARE Dental Program Claim Filing

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

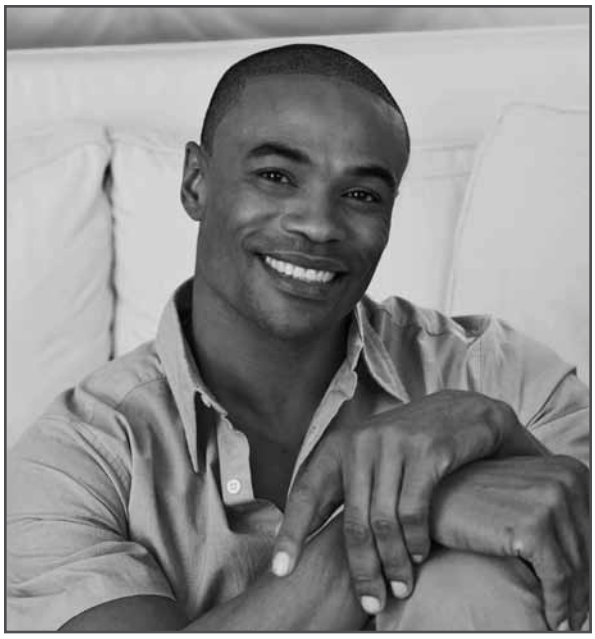
Predetermination Requests

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

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

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

TRICARE Dental Program (TDP) predeterminations are valid for 12 months from the date of finalization. The Dental Estimate of Benefit Notification contains the date that the predetermination was approved. If the reported service is performed after the predetermination approval has expired, the service will be reviewed to determine if it is still eligible for payment.



CONUS Claims

MetLife will accept claims filed on any standard dental claim submission document of the American Dental Association®. MetLife claim submission documents include instructions and are available at **https://mybenefits.metlife.com/tricare**. A separate claim submission document must be submitted for each beneficiary receiving services.

Submitting Claims

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

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

Claim-Filing Deadline

All claim submission documents should be submitted to MetLife as soon as possible after the date of service. Claims submitted more than 12 months after services were performed will be denied. A Preferred Dentist Program (PDP) dentist may not bill the patient for services that

are denied for this reason. Prompt submission is especially important for claims involving an orthodontic treatment plan, as the banding date is used to determine the start of orthodontic treatment.

Claim Payments

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

Note: Seeking care from a PDP dentist will often reduce the beneficiary's out-of-pocket costs.

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

OCONUS Claims

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

Submitting Claims

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

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

For MetLife to process claims, the following information is needed:

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

Claim-Filing Deadline

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

Claim Payments

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

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

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

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

OCONUS Point-of-Contact Program

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

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

Dental Explanation of Benefits

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

Understanding Your DEOB

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

Understanding the Dental Explanation of Benefits *Figure 8.1*

Data field	Description
Group number	TRICARE CONUS or OCONUS dental plan number
Sponsor's name	Name of the uniformed service member
Sponsor identification number	Last four digits of the sponsor's Social Security number or Department of Defense Benefits Number
Services rendered by	Name of dentist who provided the service or treatment
Beneficiary name/ relationship	Name of the beneficiary who received the services
Date processed	Date the dental explanation of benefits (DEOB) was issued
File reference	The unique number MetLife uses to identify the claim. Reference this number if you contact us with questions about the DEOB.
Document control number (DCN)	DCN—the unique number that identifies the image of the claim received. You can reference this number if you contact us with questions about the DEOB.
Date service was performed	Date the beneficiary received treatment
Tooth number/area	Tooth number, quadrant or arch (*if applicable*)
Procedure code	Procedure code identifying the service performed (*D + a four digit number*)
Fee charged	Amount charged by the dentist
Preferred Dentist Program (PDP) fee	Amount that a PDP dentist can charge per agreement with MetLife
Covered expense	Amount MetLife considers for the service. It includes adjustments for limitations and exclusions.
Plan benefit	Amount MetLife will pay for the treatment. It includes adjustments for cost-shares and maximums.
Description of service/ comments	Description of procedure, special messages, and/or message references

Note: DEOBs issued for treatment received in the OCONUS service area may include additional information not indicated on CONUS DEOBs (*e.g., foreign exchange rate*). Beneficiaries should direct inquiries to MetLife's OCONUS customer service unit. Beneficiaries may elect to view their DEOBs electronically by visiting **https://mybenefits.metlife.com/tricare**.

Questions about the DEOB

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

- Your name and date of birth
- Sponsor's DBN and/or SSN
- Beneficiary/patient name
- File control number of claim from the DEOB

Other Dental Insurance—Coordinating Benefits with the TDP

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

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

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

- Whenever a spouse's or child's other plan is primarily a medical insurance plan, but includes a dental benefit, the plan is considered secondary. The TDP is considered primary and claims should be submitted to MetLife.
- When a spouse has his or her own dental plan, the spouse's dental plan is considered primary and the TDP is secondary.
- In the case of a child who is covered under two dental plans, the primary plan is typically determined by the "birthday rule," which has been established by the National Association of Insurance Commissioners. The birthday rule determines the first plan to pay benefits based on which parent's birthday falls earlier in a calendar year. For example: If the mother's birthday is January 2 and the father's birthday is January 12, the mother's dental plan is considered primary and would pay benefits first.
- An exception to the birthday rule occurs if the other dental plan uses the "gender rule." The gender rule specifies that the male parent's dental plan is considered the primary plan. If the other dental coverage uses the gender rule in determining coordination of benefits, MetLife will defer to the gender rule and consider the male parent's dental plan as the primary plan.
- In situations where the natural parents are not married and there are two dental plans, MetLife considers the insurance plan of the parent with custody to be the primary plan. If the parent with custody has remarried, the stepparent's plan will pay before the plan of the parent without custody. An exception to this rule occurs when there is a court decree specifying which parent is responsible for insurance coverage.

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

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

Coordination of Benefits Scenarios

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

Coordination of Benefits Scenario 1 *Figure 8.2*

Carrier	Procedure	Dentist's Charge	Covered Expense	Payment Amount
Primary	Exam	$35	$28	$28
TRICARE Dental Program (*secondary*)	Exam	$35	$30	$7

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

Coordination of Benefits Scenario 2 *Figure 8.3*

Carrier	Procedure	Dentist's Charge	Covered Expense	Payment Amount
Primary	Restoration	$95	$80	$64
TRICARE Dental Program (*secondary*)	Restoration	$95	$70	$31

As shown in Figure 8.3, the primary carrier paid $64 for a $95 restoration. Under the TDP, restorations have a 20 percent beneficiary cost-share. Had TDP been primary, $56 would have been paid for this restoration. However, since the remaining balance of $31 (*$95 - $64 = $31*) is less than $56, MetLife pays the full $31 as secondary.

Coordination of Benefits Scenario 3 *Figure 8.4*

Carrier	Procedure	Dentist's Charge	Covered Expense	Payment Amount
Primary	Crown	$800	$700	$350
TRICARE Dental Program (*secondary*)	Crown	$800	$650	$325

As shown in Figure 8.4, the primary carrier paid $350 for an $800 crown. The remaining balance is $450 (*$800 - $350 = $450*). If the TDP coverage had been primary, MetLife would have paid 50 percent of $650 (*MetLife's allowance*), which is $325. Since the remaining balance of $450 is greater than $325, MetLife would only pay an additional $325 toward the $800 billed charge. The TDP beneficiary's out-of-pocket cost is $125.

Traveling and Moving with the TRICARE Dental Program

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

Traveling

CONUS to CONUS

When traveling anywhere in the CONUS service area, you are welcome to visit any licensed and authorized dentist. However, visiting a MetLife Preferred Dentist Program (PDP) dentist may save you time and money. To find a PDP dentist, please reference the inside front cover of this booklet for contact information and details.

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

CONUS to OCONUS

TRICARE Dental Program (TDP)-enrolled beneficiaries who reside in the CONUS service area are also covered in the OCONUS service area. Those enrolled in the CONUS service area that visit OCONUS countries will be subject to CONUS cost-shares and will essentially have claims paid as if visiting an out-of-network dentist. One exception is command sponsored members, who have reduced cost-shares and claim payment rules that are noted in Section 5 and Section 7 of this booklet.

OCONUS to CONUS

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

OCONUS to OCONUS

TDP-enrolled members who reside in the OCONUS service area are covered while traveling throughout OCONUS service areas.

Enrollees who seek service in the OCONUS service area and are command sponsored will have reduced cost-shares and claim payment rules that are noted in Section 5 and Section 7 of this booklet.

Moving

The TDP makes moving easy—there's no need to fill out new enrollment applications when you move.

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

To update your address, please visit **www.dmdc.osd.mil/appj/address/index.jsp**. Also, please reference the inside front cover of this booklet for details on how to locate a participating dentist.

Enrolled beneficiaries who relocate to locations within the OCONUS service area may choose, within 90 calendar days of the relocation, to terminate enrollment from the TDP.

Appeals, Grievances, Fraud, and Abuse

If you are unable to resolve an issue satisfactorily through MetLife customer service channels or your dentist, there are appeal and grievance options available to you. This section also includes procedures for reporting suspected fraud or abuse.

TRICARE Dental Program Appeals Process

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

Who Can Request an Appeal?

Parties to the initial determination can request an appeal including:

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

The *Appointment of Individual to Act as Appeal Representative Form* can be downloaded from the "Tools and Resources" section at **https://mybenefits.metlife.com/tricare**.

Who Cannot Request an Appeal?

The following cannot request an appeal:

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

What Can and Cannot Be Appealed?

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

The following issues cannot be appealed:

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

Appeal Levels

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

Level I: Reconsideration

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

How to Request a Reconsideration

The request must be in writing and include all rationale (*reason for the request*), supporting documentation (*e.g., X-rays; dated periodontal charting; clinical narratives; permanent change of station orders, if applicable; progress notes; treatment records*), and a copy of the initial determination. Additionally, the reconsideration request must be postmarked or received by

MetLife within 90 calendar days of the issue date of the dental explanation of benefits (DEOB). The issue date (*claim year and month*) is located on the upper right corner of the DEOB. Because the request for reconsideration must be filed within 90 days, the appeal request should not be delayed to obtain supporting records if the records are not readily available. If supporting records will be submitted at a later date, the appeal letter should contain the expected date of submission.

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

What Happens During a Reconsideration?

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

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

Reconsideration requests must be submitted in writing to:

CONUS/OCONUS:
MetLife
TRICARE Dental Program Appeals
P.O. Box 14183
Lexington, KY 40512

Fax: 1-855-763-1335

Level II: Formal Review

Patients may request a formal review from TRICARE Management Activity (TMA) if they disagree with MetLife's reconsideration and if the amount remaining in dispute is $50 or more. The letter containing notification of MetLife's reconsideration decision will include a notice of the patient's right to a formal review and instructions on how to request one.

How to Request a Formal Review

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

The request for formal review should be sent to:

TRICARE Management Activity
Appeals, Hearings, and Claims
Collection Division
16401 E. Centretech Parkway
Aurora, CO 80011-9066

Level III: Hearing

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

The request for a hearing should be sent to:

TRICARE Management Activity
Appeals, Hearings, and Claims
Collection Division
16401 E. Centretech Parkway
Aurora, CO 80011-9066

Grievances

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

Questions concerning the quality of care received should first be discussed with the dentist that provided the services. Concerns can often be handled by asking the dentist questions about the uniformed services dental treatment. If there are still concerns after talking to the dentist, submit them via **https://mybenefits.metlife.com/tricare** in the "Tools & Resources" section or in writing to MetLife at:

MetLife
TRICARE Dental Program
Quality of Care—Grievances
P.O. Box 14184
Lexington, KY 40512

Fax: 1-855-763-1336

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

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

Fraud and Abuse

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

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

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

For example:

- Verify the date of service
- Verify the type of services rendered
- Verify the payment issued was for the actual rendered services

MetLife, as a federal contractor, is forbidden to pay claims for services rendered by those dentists or entities that have been sanctioned by the U.S. Department of Health and Human Services, Office of Inspector General. Reasons for the sanctions include convictions for program-related fraud, patient abuse, and licensing-board actions. The director of TMA (*or designee*) also has sanction authority. In either case, the dentist or entity that has been sanctioned has forfeited his or

her entitlement to bill MetLife or the beneficiary for the rendered services. MetLife will deny the services and issue a DEOB message that states that the dentist or entity may not bill anyone for the denied services.

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

Reporting Fraud and Abuse

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

- Submit written correspondence directly to:

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

- Call the toll-free "Fraud Hotline" at **1-800-462-6565**

The SIU maintains a 24-hour confidential voice mailbox for reporting suspected fraud.

Acronyms

ADA	American Dental Association
ADFM	Active duty family member
ADSM	Active duty service member
BCAC	Beneficiary Counseling and Assistance Coordinator
BWE	Beneficiary Web Enrollment
DBN	Department of Defense Benefits Number
DCN	Document control number
DEERS	Defense Enrollment Eligibility Reporting System
DEOB	Dental explanation of benefits
DoD	Department of Defense
DTF	Uniformed services dental treatment facility
FPD	Full partial denture
HIPAA	Health Insurance Portability and Accountability Act
ID	Identification
IRR	Individual Ready Reserve
MTF	Military treatment facility
NARF	Non-Availability and Referral Form
ODTF	Overseas uniformed services dental treatment facility
OLM	Orthodontic lifetime maximum
PCS	Permanent change of station
PDP	Preferred Dentist Program
POA	Power of attorney
SIU	Special Investigations Unit
SSN	Social Security number
TAMP	Transitional Assistance Management Program
TAO	TRICARE Area Office
TDP	TRICARE Dental Program
TMA	TRICARE Management Activity
TMD	Temporomandibular joint dysfunction
TOPD	TRICARE OCONUS Preferred Dentist
TRDP	TRICARE Retiree Dental Program
TSC	TRICARE Service Center

Glossary of Terms

Adjunctive Dental Care

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

Allowable Charge/Allowance/Allowed Fee

The fee charged by a dentist that MetLife will consider for payment. For a Preferred Dentist Program dentist, it is the dentist's normal charge, or negotiated fee, whichever is lower. For non-network dentists, it is their fee, subject to caps, to reflect the range of reasonable and customary charges by dentists in the area. As always, final payment to the beneficiary or dentist may be impacted by TDP limitations and exclusions.

Amalgam

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

American Dental Association (ADA)

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

Appeals/Reconsiderations

Procedures provided for beneficiaries and dentists who disagree with MetLife's claims decisions.

Assignment of Benefits

When a beneficiary signs the assignment of benefits statement on a claim submission document, he or she is allowing MetLife to send payment directly to the dentist. If the assignment of benefits provision is not signed, MetLife's payment will be sent to the beneficiary, and he or she will be responsible for paying the dentist.

Authorized Dentist

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

Authorized Provider

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

*Beneficiary (*member*)*

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

Beneficiary Counseling and Assistance Coordinator (BCAC)

A military or government employee usually located at a military treatment facility who can address health care issues and concerns.

Benefits

Dental services received by enrolled beneficiaries for which all or part of the cost is authorized and paid for by the TDP.

Bridge

Prosthetic (*false*) tooth or row of teeth that spans between two natural teeth to replace missing or lost teeth.

By-Report Procedures

Procedures provided in circumstances that require written justification/documentation from the treating dentist.

Claim

Request for payment for services rendered.

Claim Submission Document

Document used either to submit a claim for payment or request a predetermination. If the date of service is left blank, the claim submission document is considered a predetermination request.

Command Sponsored

Command sponsored is defined as a privilege granted by the commander so that the service member's family may accompany the service member.

CONUS Service Area

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

Coordination of Benefits

Rules that determine which plan pays benefits first and which plan pays benefits second.

Cost-Share

The amount the sponsor/beneficiary/patient/family member is required to pay for the services rendered.

Crowns

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

Defense Enrollment Eligibility Reporting System (DEERS)

DEERS serves as a centralized Department of Defense data repository of personnel and health care benefits distributed to uniformed services members. DEERS is a functional component of the Defense Manpower Data Center.

Dental Estimate of Benefits (Predetermination)

Written estimate provided by MetLife in response to a request by a dentist or beneficiary for an estimate of coverage for future dental services.

Dental Explanation of Benefits (DEOB)

Computer-generated notice mailed to beneficiaries and dentists explaining benefits determinations (*e.g., type of service received, the allowable charge, the amount billed, and amount payable by MetLife*).

Dental Treatment Facility (DTF)

A facility operated by the military that provides dental care to eligible TRICARE beneficiaries.

Denture

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

Diagnostic Services

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

Eligibility

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

Endodontic Exclusion

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

Enrollee

A beneficiary (*member*) enrolled in the TDP.

Exams

An evaluation can be either an initial (*comprehensive oral evaluation*) or periodic check on the condition of the mouth.

Exclusion

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

Fillings

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

Fixed Uniformed Services Dental Treatment Facility (DTF)

Facilities that are staffed year-round and provide dental care to active duty service members on a routine basis and to active duty family members under certain circumstances. Fixed DTFs are sometimes referred to as "full-time" DTFs.

Fluoride Treatments

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

General Anesthesia

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

Gingivectomy

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

Implant

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

Individual Ready Reserve (IRR)

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

Inlays and Onlays

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

In-Process Orthodontic Treatment

Orthodontic treatment that began prior to the patient's enrollment in the TDP administered by MetLife.

Integral

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

Lock-In Period

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

Lock-Out Period

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

Maximums

Total dollar amount per beneficiary payable under the TDP. There is an annual maximum of $1,300 for all services with the exception of orthodontic treatment, which has a lifetime maximum of $1,750. There is an additional $1,200 maximum for dental care necessitated by an accident.

*Member (*Beneficiary*)*

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

MetLife

The administrator and underwriter of the TDP.

MetLife Dentist Consultant

Dentists who are contracted by MetLife to review claim submission documents, predetermination requests, and appeals.

Military Treatment Facility (MTF)

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

National Guard and Reserve

The National Guard and Reserve include members of the Army National Guard, Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard, Air Force Reserve, and U.S. Coast Guard Reserve.

Non-Availability and Referral Form (NARF)

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

Non-network Dentist

A dentist who has not signed a participating agreement with MetLife.

Occlusion

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

OCONUS Service Area

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

Oral Exam

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

Oral Surgery

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

Orthodontic Services

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

Osseous Surgery

Surgery associated with periodontal disease.

Other Dental Insurance

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

Other than Special Mobilization Category (Individual Ready Reserve)

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

Overseas Uniformed Services Dental Treatment Facility (ODTF)

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

Periodontal Services

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

Permanent Change of Station (PCS)

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

Plan Year

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

*Predetermination (*Dental Estimate of Benefits*)*

Written estimate provided by MetLife in response to a request by a dentist or beneficiary for an estimate of coverage for future dental services.

Preferred Dentist Program (PDP) Dentist

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

Premium

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

Procedure Codes

Codes used to identify and define specific dental services.

Prophylaxis

Cleaning and removal of plaque, stains, and calculus on the teeth, performed by a dentist or dental hygienist. Ideally performed at least every six months. Also referred to as "prophy."

Prosthetics

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

Prosthodontic Services

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

Provider

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

Pulpotomies

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

Ready Reserve

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

Reconsideration

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

Resin

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

Root Canal

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

Sealants

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

Selected Reserve of the Ready Reserve

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

Space Maintainers

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

Special Investigations Unit (SIU)

MetLife's fraud and abuse investigation department for reporting suspected fraud if a beneficiary believes a dentist or entity received insurance money through the submission of a false claim.

*Special Mobilization Category (*Individual Ready Reserve*)*

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

Sponsor

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

Student

Beneficiary up to age 23 who is enrolled in a full-time course of study at an approved institution of higher learning, and for whom the sponsor provides over 50 percent of the financial support.

TDP Enrollment Authorization Document

The *TDP Enrollment Authorization* document is used to enroll in the TDP, to add or remove family members from a policy, to cancel a policy, and to update members' addresses and telephone numbers. The document must be submitted by the uniformed services sponsor or an individual with power of attorney.

Temporomandibular Joint Dysfunction (TMD)

TMD is an acute or chronic inflammation of the temporomandibular joint—the "hinges" between the lower jawbone and the bones of the head/skull.

TRICARE Area Office (TAO)

TAOs are located in certain overseas areas to assist beneficiaries who live or who are traveling overseas. A TAO completes *Non-Availability and Referral Forms* for orthodontic treatment in OCONUS areas, and submits claims to MetLife for reimbursement on a beneficiary's behalf.

TRICARE Dental Program (TDP)

Dental plan offered by the Department of Defense through the TRICARE Management Activity and administered by MetLife.

TRICARE Management Activity (TMA)

The government office responsible for oversight of the TDP contract.

TRICARE OCONUS Preferred Dentist (TOPD)

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

TRICARE Retiree Dental Program (TRDP)

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

TRICARE Service Center (TSC)

Each region is served by TSCs, which are staffed by beneficiary service representatives who can explain the different TRICARE options and help beneficiaries choose the plan that suits them best.

Uniformed Services

The uniformed services include the U.S. Air Force, U.S. Army, U.S. Navy, U.S. Marine Corps, U.S. Coast Guard, Commissioned Corps of the National Oceanic and Atmospheric Administration, and U.S. Public Health Service.

X-Rays

Radiation used for diagnostic purposes to photograph the bone tissue of the tooth above and below the gum line.

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by the TRICARE Dental Program (TDP) and how it will be used.	
AUTHORITY:	10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.13, TRICARE Dental Program; 38 U.S.C. 1781, Medical Care for Survivors and Dependents of Certain Veterans; and E.O. 9397 (SSN), as amended.
PURPOSE:	To obtain information from an individual to provide for enrollment, processing of claims, and customer service to individuals eligible for TRICARE Dental Program benefits.
ROUTINE USES:	Information collected may be used and disclosed generally as permitted under 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules, as implemented by DoD 6025.18-R, the DoD Health Information Privacy Regulation. In addition to those disclosures generally permitted under 5 U.S.C. 552a (b) of the Privacy Act of 1974, the DoD "Blanket Routine Uses" under 5 U.S.C. 552a (b) (3) apply to this collection. Information from this system may be shared with federal, state, local, or foreign government agencies, and with private business entities, including individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation.
DISCLOSURE:	Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the denial of benefits.

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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 Dental 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. MetLife and each member of the MetLife family of companies (an "Affiliate") strongly believe 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 protected health information we have about you which relates to your MetLife Dental insurance coverage ("Protected Health Information"), and how we may use and disclose this information. Protected Health Information 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 Protected Health Information 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, Institutional Business HIPAA Privacy Office, P.O. Box 6896 Bridgewater, NJ 08807-6896.

We are required by law to:

- maintain the privacy of your Protected Health Information;
- provide you this notice of our legal duties and privacy practices with respect to your Protected Health Information; and
- follow the terms of this notice.

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

We will **not disclose** your Protected Health Information to any other company for their use in marketing their products to you. However, as described below, we will use and disclose Protected Health Information about you for business purposes relating to your Dental Insurance coverage.

The main reasons for which we may **use** and may **disclose** your Protected Health Information are to evaluate and process any requests for 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, together with some examples.

- **For Payment:** We may use and disclose Protected Health Information to pay for benefits under your Dental Insurance coverage. For example, we may review Protected Health Information contained on claims to reimburse providers for services rendered. We may also disclose Protected Health Information to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose Protected Health Information 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 Protected Health Information 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. We may also disclose Protected Health Information to Affiliates, and to business associates outside of the MetLife family of companies, if they need to receive Protected Health Information to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of Protected Health Information. Examples of business associates are: billing companies, data processing companies, or companies that provide general administrative services. Protected Health Information may be disclosed to reinsurers for underwriting, audit or claim review reasons. Protected Health Information may also be disclosed as part of a potential merger or acquisition involving our business in order to make an informed business decision regarding any such prospective transaction.
- **Where Required by Law or for Public Health Activities:** We disclose Protected Health Information 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 Protected Health Information to a governmental agency or regulator with health care oversight responsibilities. We may also release Protected Health Information to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.
- **To Avert a Serious Threat to Health or Safety:** We may disclose Protected Health Information to avert a serious threat to someone's health or safety. We may also disclose Protected Health Information 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 Protected Health Information 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.
- **For Law Enforcement or Specific Government Functions:** We may disclose Protected Health Information in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose Protected Health Information 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 Protected Health Information about you in response to a court or administrative order. We may also disclose Protected Health Information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the Protected Health Information requested. We may disclose Protected Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.
- **Other Uses of Protected Health Information:** Other uses and disclosures of Protected Health Information 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 Protected Health Information 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. 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 We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your Protected Health Information. Should you have questions about a specific right, please write to us at the location listed in our discussion of that right.

- **Right to Inspect and Copy Your Protected Health Information:** In most cases, you have the right to inspect and obtain a copy of the Protected Health Information that we maintain about you. To inspect and copy Protected Health Information, you must submit your request in writing to *MetLife, P.O. Box 14587, Lexington, KY 40512*. To receive a copy of your Protected Health Information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of Protected Health Information will not be made available for inspection and copying. This includes Protected Health Information 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 Protected Health Information. 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 Protected Health Information:** If you believe that your Protected Health Information is incorrect or that an important part of it is missing, you have the right to ask us to amend your Protected Health Information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to *MetLife, P.O. Box 14587, Lexington, KY 40512*. 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 Protected Health Information that:
  - is accurate and complete;
  - was not created by us, unless the person or entity that created the Protected Health Information is no longer available to make the amendment;
  - is not part of the Protected Health Information kept by or for us; or
  - is not part of the Protected Health Information 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 Protected Health Information about you. This list will not include disclosures made for treatment, payment, health care operations, for purposes of national security, made to law enforcement or to corrections personnel or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to *MetLife, P.O. Box 14587, Lexington, KY 40512*. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). 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 any costs are incurred.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on Protected Health Information 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 to *MetLife, P.O. Box 14587, Lexington, KY 40512*. 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 Protected Health Information 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 Protected Health Information 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 to *MetLife, P.O. Box 14587, Lexington, KY 40512* and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **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 Department of Health and Human Services. To file a complaint with us, please contact MetLife, Institutional Business HIPAA Privacy Office, P.O. Box 6896 Bridgewater, NJ 08807-6896. 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 (908) 253-2706 or at HIPAAprivacyInst@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 Protected Health Information we already have about you as well as any Protected Health Information 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, but only 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 contact us at HIPAAprivacyInst@metlife.com, (908) 253-2706 or write to us at MetLife, Institutional Business HIPAA Privacy Office, P.O. Box 6896 Bridgewater, NJ 08807-6896.

Effective- {01012012}

Notes

TRICARE Expectations for Beneficiaries

According to the Department of Defense (DoD), as a TRICARE beneficiary, you should expect to have the following abilities and support:

- **Get information:** You should expect to receive accurate, easy-to-understand information from written materials, presentations, and TRICARE representatives to help you make informed decisions about TRICARE programs, medical professionals, and facilities.
- **Choose providers and plans:** You should expect a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.
- **Emergency care:** You should expect to access medically necessary and appropriate emergency health care services as is reasonably available when and where the need arises.
- **Participate in treatment:** You should expect to receive and review information about the diagnosis, treatment, and progress of your conditions, and to fully participate in all decisions related to your health care, or to be represented by family members or other duly appointed representatives.
- **Respect and nondiscrimination:** You should expect to receive considerate, respectful care from all members of the health care system without discrimination based on race, color, national origin, or any other basis recognized in applicable law or regulations.
- **Confidentiality of health information:** You should expect to communicate with health care providers in confidence and to have the confidentiality of your health care information protected to the extent permitted by law. You also should expect to have the ability to review, copy, and request amendments to your medical records.
- **Complaints and appeals:** You should expect a fair and efficient process for resolving differences with health plans, health care providers, and institutions that serve you.

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

- **Maximize your health:** You should maximize healthy habits, such as exercising, not smoking, and maintaining a healthy diet.
- **Make smart health care decisions:** You should be involved in health care decisions, which means working with providers to provide relevant information, clearly communicate wants and needs, and develop and carry out agreed-upon treatment plans.
- **Be knowledgeable about TRICARE:** You should be knowledgeable about TRICARE coverage and program options.
- **You also should:**
  - Show respect for other patients and health care workers
  - Make a good-faith effort to meet financial obligations
  - Use the disputed claims process when there is a disagreement

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Directory of Resources

Online

Visit www.tricare.mil/dental or
https://mybenefits.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

Defense Manpower Data Center Support Office
400 Gigling Road
Seaside, CA 93955-6771

Verify Eligibility: 1-800-538-9552

Dental Provider Listings

Visit https://mybenefits.metlife.com/tricare
or contact customer service

www.tricare.mil

TRICARE®

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