TRICARE Dental Program
Benefits, Limitations, and Exclusions

January 2020

Note: To download the *TRICARE Dental Program Handbook*, visit **www.tricare.mil/publications**.

Note: All time-restricted benefits start new with the start of dental care delivery for this contract. Time periods for time-sensitive and time-restricted benefits must be clearly spelled out in the contractor's benefit booklet, to include examples for the enrollees.

These benefits, exclusions, and limitations currently conform to the American Dental Association (ADA) Current Dental Terminology (CDT) 2020 Dental Procedure Codes.

1. Summary of Benefit Maximums

1. Annual Benefit Maximum – The annual maximum is $1,500 of paid allowable charges, per enrollee per contract year. The entire annual maximum applies beginning on the TDP enrollment effective date, regardless of when during the year an individual enrolls; therefore a new annual benefit maximum begins again at the start of each contract year. The allowable amount paid by the contractor for certain diagnostic and preventive care services and emergency services shall not be included in the annual benefit maximum. The allowable amounts paid for all other covered services shall be included in the annual benefit maximum. Enrollee cost shares shall not count against benefit maximums.

2. Orthodontics – A lifetime maximum of $1,750 is allowed for each enrollee and the annual maximum will not apply. See age limitations under Orthodontic Services below.

3. Dental Accident Coverage - A separate annual maximum benefit of $1,200 is provided for each enrollee for dental accident coverage. The contractor shall pay claims in accordance with the benefit limitations and cost shares for dental accident treatment defined as follows:

    a. Covered services for the program, excluding orthodontics, are subject to all applicable general policies and exclusions, when provided for conditions caused directly by external and accidental means.

    b. Dental accident benefits shall be limited to services provided to an eligible person within 180 days following the date of the accident, and shall not include any services for conditions caused by an accident occurring before the enrollee’s eligibility date.

    c. Once the $1,200 accident maximum is reached, benefits will be paid up to the annual $1,500 maximum, with applicable benefit limitations and cost share amounts.

4. OCONUS Locations – See Section J, Attachment J-6a and 6b for calculation of benefit maximums.

5. The contractor shall ensure that following exhaustion of the annual dental benefit maximum or the lifetime orthodontic benefit maximum under this contract, enrollees will continue to receive the benefit of the discounted network provider rates.

2. 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 which do not meet accepted standards of practice are not billable to the patient by a network dentist unless the dentist notifies the enrollee of his or her liability prior to treatment and the enrollee chooses to receive the treatment. Network dentists shall document such notification in their 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 enrollee of his or her liability prior to treatment and the enrollee chooses to receive the treatment. This is because such services are not billable to the enrollee, and there would be no amount in dispute to consider at appeal. The enrollee 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 TRICARE/Medical policy, are not covered under the TDP.

5. Procedures should be reported using the ADA'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 enrollee for services that are denied for this reason.

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

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

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

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

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

12. Payment for diagnostic services performed in conjunction with orthodontics is applied to the enrollee's annual maximum, except as indicated by an asterisk under "Diagnostic Services."

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

14. The 24-month time limitation for periodontal services (e.g., osseous surgery, etc.) is based on the exact date of service (day and month) when the procedure was performed.

15. The 36-month time limitation for a panoramic or complete series of X-rays or a denture reline/rebase is calculated to the month in which the service was performed.

16. The 36-month time limitation for sealants is based on the exact date of service (month and day) when the service was performed.

17. 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.

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

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

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

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

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

Contractor will request only those X-rays that are generally taken as part of diagnosis and treatment planning. If, for some reason, X-rays were not taken or are not available, a brief explanation should be included with the claim.

"Report required" means that these services will be paid only in well documented circumstances and documentation of the circumstances must be submitted with the claim.

"Periodontal charting required" means that complete periodontal charting must be submitted for review.

Note: The requirement for providers to submit radiographs and other clinical documentation for certain specified procedures, as indicated throughout this attachment, may be relaxed by the contractor.

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

4. Diagnostic Services

R = Report required

Note: The annual payment maximum is not affected by those procedure codes listed below that are followed by an asterisk "*****".

Procedure Code	Description of Service
D0120*****	Periodic oral evaluation - established patient
D0140	Limited oral evaluation - problem focused
D0145*****	Oral evaluation for patient under 3 years of age and counseling with primary caregiver
D0150*****	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*****	Intraoral - complete series of radiographic images
D0220*****	Intraoral - periapical first radiographic image
D0230*****	Intraoral - periapical - each additional radiographic image
D0240*****	Intraoral - occlusal radiographic image
D0250	Extraoral - 2-D projection radiographic image created using a stationary radiation source, and detector
D0251	Extraoral - posterior dental radiographic image
D0270*****	Bitewing - single radiographic image
D0272*****	Bitewings - two radiographic images
D0273*****	Bitewings - three radiographic images
D0274*****	Bitewings - four radiographic images
D0330*****	Panoramic radiographic image
D0340	2-D cephalometric radiographic image – acquisition, measurement and analysis
D0411	HbA1c in office point of service testing
D0412	Blood glucose level test – in office using a glucose meter
D0425*****	Caries susceptibility tests

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**,** and 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, patients who have not had an oral evaluation within the previous 36 months from the same office, and 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 three are covered in a consecutive 12-month period. Only two of these oral evaluations (D0145) may be from the same office. A third evaluation (D0145) is covered only if it is rendered by a different office. However, the total number of evaluations (D0145, D0150, and D0120) for a patient under age three in a consecutive 12-month period cannot exceed a total of three.

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. Re-evaluations are considered integral procedures.

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

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

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

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

11. One set of bitewing X-rays, consisting of up to four bitewing X-rays per visit, is covered during a consecutive 12-month period. A complete series of X-rays counts as an occurrence of bitewing X-rays.

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 service 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 a radiograph laboratory unless billed by a licensed dentist. Any difference between the allowance for the X-rays and the fee charged by the X-ray laboratory cannot be charged to the patient.

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

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

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

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

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

20. X-rays are not covered when performed in conjunction with the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMD).

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

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

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

24. Caries susceptibility tests are payable only in conjunction with an intensive regimen of home preventive therapy (including prescription mouth rinses) to determine if the therapy should be continued. The test is payable once per member per lifetime. The regimen must have been initiated immediately following completion of restorative care for a recent episode of rampant caries.

25. Caries susceptibility tests are not payable on a routine basis for patients with unrestored carious lesions, or when performed for patient education.

26. HbA1c in-office point of service testing (D0411) and blood glucose level test (D0412) are covered for family members only. Reserve sponsors are not covered for this benefit.

5. Preventive Services

Note: The annual payment maximum is not affected by those procedure codes listed below that are followed by an asterisk "*****".

Procedure Code	Description of Service
D1110*****	Prophylaxis - adult
D1120*****	Prophylaxis - child
D1206*****	Topical application of fluoride varnish
D1208*	Topical application of fluoride-excluding varnish
D1510	Space maintainer - fixed -– unilateral – per quadrant
D1516	Space maintainer – fixed – bilateral, maxillary
D1517	Space maintainer – fixed – bilateral, mandibular
D1520	Space maintainer - removable -– unilateral – per quadrant
D1526	Space maintainer – removable – bilateral, maxillary
D1527	Space maintainer – removable – bilateral, mandibular
D1551	Re-cement or re-bond bilateral space maintainer - maxillary
D1552	Re-cement or re-bond bilateral space maintainer – mandibular
D1553	Recement or re-bond unilateral space maintainer – per quadrant
D1556	Removal of fixed unilateral space maintainer – per quadrant
D1557	Removal of fixed bilateral space maintainer - maxillary
D1558	Removal of fixed bilateral space maintainer mandibular
D1575	Distal shoe space maintainer – fixed -– unilateral – per quadrant
D1999	Unspecified preventive procedure, by report

Benefits and Limitations for Preventive Services:

1. Two routine prophylaxes are covered in a consecutive 12-month period.

2. A third prophylaxis in a consecutive 12-month period is allowed for pregnant patients. Patients should ensure that the pregnancy is noted clearly on the claim submission form.

3. A third prophylaxis in a consecutive 12-month period is allowed for patients diagnosed with diabetes, coronary artery disease (heart), cerebral vascular disease (stroke), rheumatoid arthritis, lupus, oral cancer and recipients of an organ transplant. The dentist must indicate the medical diagnosis code on the claim form. Patients should ensure that the medical diagnosis is noted clearly on the claim submission form.

4. Adult prophylaxes will be allowed on patients 13 years of age and older.

5. Routine prophylaxes may be allowed when eligible and when performed by the same dentist on the same day as one partial quadrant scaling and root planning (code D4342) or one partial quadrant periodontal surgery (codes D4211, D4241, and D4261) since the remaining healthy teeth in the remaining quadrants still may need prophylaxis.

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, gingivectomies or gingivoplasties, gingival flap procedures, mucogingival surgery, or osseous surgery.

7. A routine prophylaxis includes associated scaling and polishing procedures. There are no provisions for any additional allowance based on degree of difficulty.

8. Two topical fluoride applications are covered in a consecutive 12-month period.

9. Topical fluoride applications, which may include fluoride varnish applications, are covered only when a prescription-strength fluoride product designed solely for use in the dental office is used and delivered to the teeth under the direct supervision of a dental professional. The use of a prophylaxis paste containing fluoride qualifies for payment only as a component of a routine prophylaxis.

10. Space maintainers and distal shoe space maintainer (D1575) are fully covered without cost shares for patients under age 19. Coverage is limited to posterior teeth.

11. Repair of a damaged space maintainer is not a covered benefit.

12. Recementation or rebonding of a space maintainer is covered once per 12-month period. Recementation or rebonding provided within 12 months of placement by the same dentist is considered integral.

13. 13. Removal of a space maintainer is considered an integral procedure unless performed by a dentist or practice that did not originally place the appliance.

6. Sealants

Procedure Code	**Description of Service**
D1351	Sealant - per tooth
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth
D1353	Sealant repair – per tooth
D1354	Interim caries arresting medicament application – per tooth

Benefits and Limitations for Sealants:

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

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

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

4. Preventive resin restoration (code D1352) on 1st and 2nd permanent molars is covered as a preventive service at the same benefit level as a dental sealant code D1351. Also, the service is covered to the same age limit and frequency limit as dental sealants with a combined frequency limitation with dental sealants D1351.

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

7. Restorative Services

Procedure 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
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 surface, posterior
D2393	Resin-based composite – three surface, 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 to be a pin buildup (D2950).

6. Preventive resin restorations or other restorations that do not extend into the dentin are considered sealants for purposes of determining benefits.

7. Restorative services are covered only when necessary due to decay, tooth fracture, attrition, erosion, abrasion, congenital or developmental defects. Restorative services are not benefits 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 the contractor for the amalgam restoration.

14. Restorations are not covered when performed after the placement of any type of crown or onlay, on the same tooth and by the same dentist, unless approved by the contractor.

15. The payment for restorations includes all related services including, but not limited to, etching, bases, liners, dentinal adhesives, local anesthesia, polishing, caries removal, preparation of gingival tissue, occlusal/contact adjustments, and detection agents.

16. Resin-based composite crowns (D2390) placed on anterior teeth are limited to one per tooth per 12-month period. Repair or replacement within 12 months of placement by the same dentist is considered integral. Placement within 12 months of a previous restoration is not covered. A separate fee is not chargeable to the patient by a network dentist. If a diagnosis warrants a D2390 on a tooth that has

previously been restored within the last 12 months by the same dentist, the service may be considered for coverage. A report justifying the procedure must be submitted for review by the contractor.

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 to any age, and on permanent anterior and premolar teeth of patients age 14 and younger. They are limited to once per tooth, per lifetime.

20. Prefabricated esthetic coating 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 member is responsible for the difference between the dentist's charge for the esthetic coating stainless steel crown and the amount paid by the contractor for the stainless steel crown.

8. Other Restorative Services

X = X-ray required **R** = report required

Procedure 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
D2750 **X**	Crown - porcelain fused to high noble metal
D2751 **X**	Crown - porcelain fused to predominately base metal
D2752 **X**	Crown - porcelain fused to noble metal
D2753 **X**	Crown – porcelain fused to titanium and titanium alloys
D2780 **X**	Crown - 3/4 cast high noble metal
D2781 **X**	Crown - 3/4 cast predominately 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 predominately base metal
D2792	**X**	Crown - full cast noble metal
D2794	**X**	Crown -– titanium and titanium alloys
D2910		Recement or rebond inlay, onlay, veneer or partial coverage restoration
D2915		Recement cast or re-bond indirectly fabricated or prefabricated post and core
D2920		Re-cement or re-bond crown
D2941		Interim therapeutic restoration – primary dentition
D2950	**X**	Core buildup, including any pins when required
D2954	**X**	Prefabricated post and core in addition to crown
D2960	**X**	Labial veneer (resin laminate) - chairside
D2961	**X**	Labial veneer (resin laminate) - laboratory
D2962	**XR**	Labial veneer (porcelain laminate) - laboratory
D2980		Crown repair necessitated by restorative material failure
D2982		Onlay repair necessitated by restorative material failure
D2983		Veneer repair necessitated by restorative material failure

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 12 years of age 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 the contractor.

4. Core buildups (D2950), refers to the building up of coronal structure when there is insufficient retention for a separate extra coronal restorative procedure. A core buildup is not a filler used to eliminate any undercut, box form or concave irregularity in a preparation.

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

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

7. Replacement of crowns, onlays, buildups, and posts and cores is covered only if the existing crown, onlay, buildup, or post and core was inserted at least five years prior to the replacement and satisfactory evidence is presented that the existing crown, onlay, buildup, or post and core is not and cannot be made serviceable. The five-year time limitation on crowns, onlays, buildups, and posts and cores does not apply if the member moves as a result of a Permanent Change of Station (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 service 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 payable 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 in preparation for a permanent crown are considered integral to the placement of the permanent crown.

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

13. When performed as an independent procedure, the placement of a post is not a covered benefit. Posts are only eligible when provided as part of a buildup for a crown and are considered integral to the buildup.

14. Diagnostic pretreatment X-rays will be requested for codes D2960, D2961 and D2962 in order to determine if the service is cosmetic or due to fracture/decay or severe developmental or congenital disfigurement.

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

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

17. Labial veneers are covered only when placed to treat severe developmental or congenital disfigurement. However, if a restoration is necessary due to tooth fracture or decay, payment may be made for an anterior resin restoration toward the cost of the veneer, and the patient is responsible for any difference between

the allowance for a resin restoration and the dentist's charge for the veneer. Treatment of peg lateral incisors is a covered benefit as long as the method of restoration (labial veneer or crown) is a TDP covered procedure.

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

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

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

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

9. Endodontic Services

X = X-ray required
R = report required

Procedure Code	**Description of Service**
D3120	Pulp cap - indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament
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	Endodontic therapy, anterior tooth (excluding final restoration)
D3320	Endodontic therapy, premolar tooth (excluding final restoration)
D3330	Endodontic therapy, molar tooth (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 - premolar
D3348	Retreatment of previous root canal therapy - molar
D3351	Apexification/recalcification/ - initial visit (apical closure/calcific repair of perforations, root resorption etc.)

D3352	Apexification/recalcification/ - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection etc.)
D3353	Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
D3355	Pulpal regeneration - initial visit
D3356	Pulpal regeneration – interim medication replacement
D3357	Pulpal regeneration – completion of treatment
D3410	Apicoectomy/ - anterior
D3421	Apicoectomy/ - premolar (first root)
D3425	Apicoectomy/ - molar (first root)
D3426	Apicoectomy/ (each additional root)
D3427	Periradicular surgery without apicoectomy
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site.
D3430	Retrograde filling - per root
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery
D3450	Root amputation - per root
D3920**X**	Hemisection (including any root removal) - not including root canal therapy

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) coverage is limited to once per tooth per lifetime for primary incisor teeth for members up to, but not including, age six and for primary molars and cuspids up to, but not including, age eleven. 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 eligible 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 a covered benefit 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, and 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 a covered benefit when the dentist providing the treatment causes the perforation. All other circumstances require a pre-treatment X-ray and a report.

12. The placement of a post is not a covered benefit 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 code (D3351) includes opening tooth, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure may include first phase of complete root canal therapy.)

19. Apexification/recalcification/pulpal regeneration interim medication replacement code (D3352) includes visits in which the intra-canal medication is replaced with new medication. Includes any necessary radiographs.

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

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

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

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

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

10. Periodontal Services

X = X-ray required
C = Periodontal charting required

Procedure 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 tooth bounded spaces, per quadrant
D4241 **XC**	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant
D4249 **X**	Clinical crown lengthening - hard tissue
D4260 **XC**	Osseous surgery (including elevation of full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces, per quadrant
D4261 **XC**	Osseous surgery (including elevation of full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant
D4263 **XC**	Bone replacement graft - retained natural tooth - first site in quadrant
D4264 **XC**	Bone replacement graft - retained natural tooth - each additional site in quadrant
D4266 **XC**	Guided tissue regeneration - resorbable barrier - per site
D4267 **XC**	Guided tissue regeneration - non-resorbable barrier - per site (includes membrane removal)
D4270 **C**	Pedicle soft tissue graft procedure
D4273 **C**	Autogenous connective tissue graft (including donor and recipient sites) first tooth, implant or edentulous tooth position in graft
D4275 **C**	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft
D4276 **C**	Combined connective tissue and double pedicle graft, per tooth
D4277 C	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft.
D4278 C	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4283 **C**	Autogenous connective tissue graft (including donor and recipient sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4285 **C**	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4341 **XC**	Periodontal scaling and root planing – four or more teeth per quadrant. See "Note" below.
D4342 **XC**	Periodontal scaling and root planing – one to three teeth, per quadrant. See "Note" below.

D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit
D4910	Periodontal maintenance
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)

Note: For procedures that require X-rays and/or periodontal charting, a diagnosis should also be provided.

Note: X-rays and periodontal charting are required when submitting a claim for periodontal scaling and root planing (D4341, D4342) for all members. An exception is made for Periodontists; they do not have to submit X-rays and charting on a prepayment basis.

Note: For patients diagnosed with diabetes (medically documented), no cost shares will be applied 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 planning in the same area of the mouth within 24 months of a gingival flap procedure are not covered.

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

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

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

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

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

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

10. A single site for reporting bone replacement grafts consists of one contiguous area, regardless of the number of teeth (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 covered only when provided to treat specific types of periodontal defects (i.e., Class II furcation involvement 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
    a. provided in conjunction with (same or different date as) extractions, cyst removal or procedures involving the removal of a portion of a tooth, such as an apicoectomy or hemisection.

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

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

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

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

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

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

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

22. An oral evaluation reported in addition to periodontal maintenance will be processed as a separate procedure subject to the policy and limitations applicable to oral evaluations.

23. Payment for multiple periodontal surgical procedures (except soft tissue grafts, osseous grafts, and guided tissue regeneration) provided in the same area of the mouth during the same course of treatment is based on the fee for the greater surgical procedure. The lesser procedure is considered integral and its allowance is included in the allowance for the greater procedure. When both a bone graft and guided tissue regeneration are submitted for the same site, both procedures are eligible for benefits if approved by the contractor.

24. Procedures related to the placement of an implant (e.g., bone re-contouring and excision of gingival tissue) are not covered.

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

26. Full mouth debridement involves the preliminary removal of plaque and calculius that interferes with the ability of the dentist to perform a comprehensive oral evaluation. (Code D4355) is covered once within a consecutive 24-month period. Not to be completed on the same day as D0150, D0160, or D0180.

27. Full mouth debridement to enable comprehensive evaluation and diagnosis provided on the same day as scaling and root planning (D4341, D4342), scaling in the presence of generalized, moderate, or severe gingival inflammation (D4346), periodontal maintenance (D4910), or routine prophylaxis (D1110, D1120) is considered integral.

11. Prosthodontic Services

Prosthodontics, removable:

Procedure Code	Description of Service
D5110	Complete denture - maxillary
D5120	Complete denture - mandibular
D5130	Immediate denture - maxillary
D5140	Immediate denture - mandibular
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)
D5213	Maxillary partial denture - cast metal framework with resin denture base (including retentive/clasping materials, rests and teeth)
D5214	Mandibular partial denture - cast metal framework with resin denture base (including retentive/clasping materials, rests and teeth)

D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)
D5410	Adjust complete denture - maxillary
D5411	Adjust complete denture - mandibular
D5421	Adjust partial denture - maxillary
D5422	Adjust partial denture - mandibular
D5511	Repair broken complete denture base, mandibular
D5512	Repair broken complete denture base, maxillary
D5520	Replace missing or broken teeth - complete denture (each tooth)
D5611	Repair resin partial denture base, mandibular
D5612	Repair resin partial denture base, maxillary
D5621	Repair cast partial framework, mandibular
D5622	Repair cast partial framework, maxillary
D5630	Repair or replace broken retentive clasping materials – per tooth
D5640	Replace broken teeth - per tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture – per tooth
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)
D5741	Reline mandibular partial denture (chairside)
D5750	Reline complete maxillary denture (laboratory)
D5751	Reline complete mandibular denture (laboratory)
D5760	Reline maxillary partial denture (laboratory)
D5761	Reline mandibular partial denture (laboratory)
D5810	Interim complete denture (maxillary)
D5811	Interim complete denture (mandibular)
D5820	Interim partial denture (maxillary)
D5821	Interim partial denture (mandibular)
D5850	Tissue conditioning (maxillary)
D5851	Tissue conditioning (mandibular)
D5863	Overdenture – complete maxillary

D5864	Overdenture – partial maxillary
D5865	Overdenture – complete mandibular
D5866	Overdenture – partial mandibular

Prosthodontics, fixed

X = X-ray required **R** = report required

Procedure Code	Description of Service
D6210 **X**	Pontic - cast high noble metal
D6211 **X**	Pontic - cast predominately base metal
D6212 **X**	Pontic - cast noble metal
D6214 **X**	Pontic -– titanium and titanium alloys
D6240 **X**	Pontic - porcelain fused to high noble metal
D6241 **X**	Pontic - porcelain fused to predominately base metal
D6242 **X**	Pontic - porcelain fused to noble metal
D6243 **X**	Pontic – porcelain fused to titanium and titanium alloys
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
D6549 **X**	Resin retainer-for resin bonded fixed prosthesis
D6600 **X**	Retainer inlay - porcelain/ceramic, two surfaces
D6601 **X**	Retainer inlay – porcelain/ceramic, three or more surfaces
D6602 **X**	Retainer inlay - cast high noble metal, two surfaces
D6603 **X**	Retainer inlay - cast high noble metal, three or more surfaces
D6604 **X**	Retainer inlay - cast predominantly base metal, two surfaces
D6605 **X**	Retainer inlay - cast predominantly base metal, three or more surfaces
D6606 **X**	Retainer inlay - cast noble metal, two surfaces
D6607 **X**	Retainer inlay - cast noble metal, three or more surfaces
D6608 **X**	Retainer onlay – porcelain/ceramic, two surfaces
D6609 **X**	Retainer onlay – porcelain/ceramic, three or more surfaces
D6610 **X**	Retainer onlay - cast high noble metal, two surfaces
D6611 **X**	Retainer onlay – cast high noble metal, three or more surfaces
D6612 **X**	Retainer onlay – cast predominantly base metal, two surfaces
D6613 **X**	Retainer onlay – cast predominantly base metal, three or more surfaces
D6614 **X**	Retainer onlay – cast noble metal, two surfaces
D6615 **X**	Retainer onlay – cast noble metal, three or more surfaces
D6624 **X**	Retainer inlay - titanium
D6634 **X**	Retainer onlay - titanium
D6740 **X**	Retainer crown - porcelain/ceramic
D6750 **X**	Retainer crown - porcelain fused to high noble metal
D6751 **X**	Retainer crown - porcelain fused to predominately base metal
D6752 **X**	Retainer crown - porcelain fused to noble metal
D6753 **X**	Retainer crown – porcelain fused to titanium and titanium alloys
D6780 **X**	Retainer crown - 3/4 cast high noble metal

D6781 **X**	Retainer crown - 3/4 cast predominately base metal
D6782 **X**	Retainer crown - 3/4 cast noble metal
D6783 **X**	Retainer crown - 3/4 porcelain/ceramic
D6784 **X**	Retainer crown 3/4 – titanium and titanium alloys
D6790 **X**	Retainer crown - full cast high noble metal
D6791 **X**	Retainer crown - full cast predominately base metal
D6792 **X**	Retainer crown - full cast noble metal
D6794 **X**	Retainer crown –– titanium and titanium alloys
D6930	Re-cement or re-bond fixed partial denture
D6980	Fixed partial denture repair necessitated by restorative material failure

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, is 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 12 years of age are excluded from coverage unless specific rationale is provided indicating the necessity for that treatment and is approved by the contractor.

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

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

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

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

8. The relining or rebasing of a denture, including immediate dentures, is considered integral when performed within six months following the insertion of that denture when performed 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 16 years of age are not covered unless specific rationale is provided indicating the necessity for such treatment and is approved by the contractor.

11. Payment for a denture or an overdenture made with precious metals is based on the allowance for a conventional denture. Any additional cost is the member'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 during a 12 month period.

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

15. Indirectly fabricated post and cores are processed as an alternate benefit of a prefabricated post and core. The member is responsible for the difference between the dentist's charge for the indirectly fabricated post and core and the allowance for the prefabricated post and core.

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

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

18. Replacement of removable prostheses (D5110 through D5226) and fixed prostheses (D6210 through D6794) and buildups, posts and cores is covered only if the existing removable and/or fixed prostheses, buildup or past and core was 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 time limitation on existing removable prostheses and/or fixed prostheses does not apply if the member moves as a result of Permanent Change of Station (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 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.

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

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

21. Repairs to removable and fixed dentures (D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D6980) are each covered once per mouth area, per 24-month period.

12. Implant Services

X = X-ray required
R = Report required

Procedure Code	Description of Service
D6010	Surgical placement of implant body: endosteal implant
D6013 **R**	Surgical placement of mini implant
D6050	Surgical placement: transosteal implant
D6052	Semi-precision attachment abutment
D6056	Prefabricated abutment – includes modification and placement
D6057	Custom fabricated abutment – includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported porcelain fused to high noble alloys
D6067	Implant supported crown – high noble alloys
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominately base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment supported retainer for cast metal FPD (predominately base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer FPD – porcelain fused to high noble alloys
D6077	Implant supported retainer for metal FPD - high noble alloys
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
D6082	Implant supported crown – porcelain fused to predominantly base alloys
D6083	Implant supported crown – porcelain fused to noble alloys
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys
D6086	Implant supported crown – predominantly base alloys
D6087	Implant supported crown – noble alloys
D6088	Implant supported crown – titanium and titanium alloys
D6090 **R**	Repair implant supported prosthesis, by report

D6092	Re-cement or re-bond implant/abutment supported crown
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture
D6094	Abutment supported crown – (titanium) and titanium alloys
D6095 **R**	Repair implant abutment, by report
D6096	Remove broken implant retaining screw
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys
D6098	Implant supported retainer – porcelain fused to predominantly base alloys
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys
D6101 **X**	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of exposed implant surfaces, including flap entry and closure
D6102 **X**	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of exposed implant surfaces and flap entry and closure
D6103 **X**	Bone graft for repair of peri-implant defect – does not include flap entry and closure.
D6104	Bone graft at time of implant placement
D6110	Implant/abutment supported removable denture for edentulous arch-maxillary
D6111	Implant/abutment supported removable denture for edentulous arch-mandibular
D6112	Implant/abutment supported removable denture for partially edentulous arch-maxillary
D6113	Implant/abutment supported removable denture for partially edentulous arch-mandibular
D6114	Implant/abutment supported fixed denture for edentulous arch-maxillary
D6115	Implant/abutment supported fixed denture for edentulous arch-mandibular
D6116	Implant/abutment supported fixed denture for partially edentulous arch-maxillary
D6117	Implant/abutment supported fixed denture for partially edentulous arch-mandibular
D6118	Implant/abutment supported interim fixed denture for edentulous arch – mandibular
D6119	Implant/abutment supported interim fixed denture for edentulous arch – maxillary
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys
D6121	Implant supported retainer for metal FPD – predominantly base alloys
D6122	Implant supported retainer for metal FPD – noble alloys
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys

Benefits and Limitations for Implant Services:

1. Implant services are subject to a 50% 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 the contractor.

3. Mini implants (D6013) are covered by report, only to support a complete denture for edentulous patients. A maximum of 4 per arch per lifetime are covered.

4. Replacement of implants is covered only if the existing implant was placed at least five years prior to the replacement and the implant has failed.

5. Replacement of implant prosthetics is covered only if the existing prosthetics were placed at least five years prior to the replacement and satisfactory evidence is presented that demonstrates they are not, and cannot be made serviceable.

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

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

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

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

10. Scaling and debridement (D6081) is not to be performed in conjunction with D1110, D4910, or D4346.

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

12. D6118 is covered for mandibular only.

13. D6119 is covered for maxillary fixed dentures only.

13. Oral Surgery Services

X = X-ray required
R = Report required

Procedure Code	Description of Service
D7111	Extraction coronal remnants – primary tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony. See “Note” below
D7240	Removal of impacted tooth - completely bony. See “Note” below.
D7241 **XR**	Removal of impacted tooth – completely bony, with unusual surgical complications
D7250	Removal of residual tooth roots (cutting procedure)
D7251 **XR**	Coronectomy – intentional partial tooth removal
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280	Exposure of an unerupted tooth
D7283	Placement of a device to facilitate eruption of impacted tooth
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)
D7286	Incisional biopsy of oral tissue – soft
D7290	Surgical repositioning of teeth
D7291	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	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 **R**	Bone replacement graft for ridge preservation-per site.
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure
D7963	Frenuloplasty
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity

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. Extraction of erupted tooth (D7210) includes related cutting of gingival and bone, removal of tooth structure, minor smoothing of socket bone and closure.

4. Coronectomy (D7251) can be considered for benefits only when the patient is symptomatic and there is evidence that complete removal would put the inferior alveolar nerve at considerable risk of damage. Coronectomy submitted for predetermination requires pretreatment X-rays, description of the patient's specific symptoms, and a report explaining why complete removal would put the inferior alveolar nerve at considerable risk of damage. For services not predetermined, a copy of the operative report is also required.

5. Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow up care is considered integral to the procedure.

6. Biopsies are an eligible benefit when tissue is surgically removed for the specific purpose of histopathological examination and diagnosis.

7. Biopsies are considered integral when performed in conjunction with other surgical procedures on the same day in the same area of the mouth.

8. Charges for related services such as necessary wires and splints, adjustments, and follow up visits are considered integral to the fee for reimplantation and/or stabilization.

9. Routine postoperative care such as suture removal is considered integral to the fee for the surgery.

10. Removal of impacted third molars in patients under age 15 and over age 30 is not covered unless specific documentation is provided that substantiates the need for removal and is approved by the contractor.

11. Alveoloplasties performed in conjunction with extraction, involving less than four teeth is not covered as a separate procedure. A fee cannot be charged to the patient by a network dentist.

12. Bone grafts provided for ridge preservation (D7953) [socket grafts] are covered once per tooth, per lifetime only when provided in relation to the placement of a dental implant, and will be covered at the same benefit level as dental implants. A report is required indicating the reason why the bone graft is being placed.

13. A frenulectomy (D7960) is considered integral when provided on the same day, by the same dentist, as a frenuloplasty or periodontal surgery. A frenulectomy is surgical removal or release of mucosal and muscle elements of a buccal, labial or lingual frenum that is associated with a pathological condition, or interferes with proper oral development or treatment.

14. A frenuloplasty (D7963) is considered integral when provided on the same day, by the same dentist, as a frenulectomy or periodontal surgery.

15. Removal of residual roots (D7250) is integral when reported by the same dentist who removed the tooth.

16. Removal of a complete bony impaction with unusual surgical complications (D7241) is eligible for complicating factors such as nerve dissection, sinus closure, or aberrant tooth position. A pretreatment X-ray and report describing the complicating factor are required for review.

14. Orthodontic Services

Note: National Guard/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 reservist's expense.

Note: Diagnostic casts are payable at 50 percent of the contractor allowance, once per lifetime, when provided with covered orthodontic procedures. (The limitation does not apply if the member moves as a result of Permanent Change of Station (PCS) relocation.) Payment for diagnostic casts will be applied towards the annual maximum. For enrollees in the OCONUS service area, there is no cost-share for this service.

R = report required

Procedure Code	Description of Service
D0470	Diagnostic casts
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
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
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8690 **R**	Orthodontic treatment (alternative billing to a contract fee)
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment

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 note under the "Diagnostic Services" section.

2. Orthodontic consultations will be processed as comprehensive or periodic evaluations and are subject to the same time limitations. See "Diagnostic Services" for more information.

3. Orthodontic treatment is available for family members (non-spouse) up to, but not including, 21 years of age (or up to, but not including, 23 years of age if enrolled full-time at an accredited college or university).

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

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

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

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

8. Repair of damaged orthodontic appliances is not covered.

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

10. The rebonding and/or repair of a fixed retainer (D8698 or D8699) 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 contract fee) will be reviewed for individual consideration with any allowance being applied to the orthodontic lifetime maximum. It is only payable for services rendered by a dentist other than the dentist rendering complete orthodontic treatment.

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

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

16. D8695 is covered for family member if requested within six months following permanent change of duty station where the member chooses to voluntarily discontinue orthodontic treatment. Not covered if treatment is being continued.

15. General Services

The TDP will provide coverage for the following services. To be eligible, these services must be directly related to the covered services already listed.

R = Report required

Emergency Services

Procedure Code	Description of Service
D9110	Palliative (emergency) treatment of dental pain - minor procedure

General Anesthesia Services

R = Report required

Procedure Code	Description of Service
D9222 **R**	Deep sedation/general anesthesia – first 15 minutes
D9223 **R**	Deep sedation/general anesthesia – each subsequent 15 minute increment

Intravenous Sedation Services

R = Report required

Procedure Code	Description of Service
D9239 **R**	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes
D9243 **R**	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment

Consultation Services

Procedure Code	Description of Service
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
D9311	Consultation with a medical health care professional

Office Visit Services

Procedure Code	Description of Service
D9440	Office visit - after regularly scheduled hours

Medications Services

R=Report required

Procedure Code	Description of Service
D9610 **R**	Therapeutic parenteral drug, single administration
D9612 **R**	Therapeutic parenteral drugs, two or more administrations, different medications

Post-surgical Services

R=Report required

Procedure Code	Description of Service
D9930 **R**	Treatment of complications (post-surgical) unusual circumstances, by report
D9932	Cleaning and inspection of removable complete denture, maxillary
D9933	Cleaning and inspection of removable complete denture, mandibular
D9934	Cleaning and inspection of removable partial denture, maxillary
D9935	Cleaning and inspection of removable partial denture, mandibular

Miscellaneous Services

X = X-ray required
R = Report required

Procedure Code	Description of Service
D9941	Fabrication of athletic mouthguard
D9944 **R**	Occlusal guard – hard appliance, full arch
D9945 **R**	Occlusal guard – soft appliance, full arch
D9946 **R**	Occlusal guard – hard appliance, partial arch
D9974 **X**	Internal bleaching - per tooth

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 where 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 a "per visit" code and is payable once per provider per date of service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21. Cleaning and inspection of dentures (D9932-D9935) are covered once per 12-month period. They are considered integral to a prophylaxis or evaluation provided on the same date by the same dentist.

16. Nitrous Oxide Coverage for DoD's Special Needs Enrollees Miscellaneous Services

R = Report required

Procedure Code		Description of Service
D9230	**R**	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis

Special Needs enrollees who are identified as having the following medical conditions will be eligible for nitrous oxide: Medical ICD-10 codes 317-319 (mental retardation); 330-337 (hereditary and degenerative disease of the central nervous system); 340-344 (other disorders of the central nervous system); 345 (epilepsy); and 290-299 (psychoses, including autism).

The service will remain a non-covered service as required in this attachment, but the contractor shall pay 100% of the cost of nitrous oxide with no cost-share when the enrollee is treated by a network provider. This service will not count toward the annual maximum. When a non-network provider is utilized for this service, it will still be covered at 100% of the contractor's maximum allowable charge. As with any non-network care, the enrollee will be financially responsible for the difference between the maximum allowable charge and the provider's charge.

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

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

The determination that an alternate 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.

17. Non-Covered Services

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

1. Any dental service or treatment not specifically listed as a covered service.

2. Those not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, the contractor will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law.

3. Those submitted by a dentist, which are for the same services performed on the same date for the same member by another dentist.

4. Those which are experimental or investigative (deemed unproven).

5. Those which are for any illness or bodily injury which 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 member claims the benefits or compensation.

6. Those which are later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law.

7. Those provided free of charge by any Governmental unit, except where this exclusion is prohibited by law.

8. Those for which the patient would have no obligation to pay in the absence of this or any similar coverage. Treatment rendered by a dentist or physician who is a close relative, including spouse, children, adopted and step relatives, sisters and brothers, parents and grandparents of the beneficiary will be declined as not a covered benefit under the TDP.

9. Those received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

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

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

12. Those which are not medically or dentally necessary, or which 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/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 which are for unusual procedures and techniques.

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

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 Temporomandibular Joint Dysfunction (TMD).

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

23. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

24. Restorations which 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, except for Special Needs enrollees with specific medical conditions.

31. Oral sedation.

32. State or territorial taxes on dental services performed.

18. Adjunctive Services

1. Adjunctive dental care is dental care that is:

    a. Medically necessary in the treatment of an otherwise covered medical (not dental) condition.

    b. An integral part of the treatment of such medical condition.

    c. Essential to the control of the primary medical condition.

    d. 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).

2. The TDP does not cover services that are adjunctive dental care. 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:

    a. Treatment for relief of Myofacial Pain Dysfunction Syndrome or Temporomandibular Joint Dysfunction (TMD).

    b. 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.

    c. 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.

    d. Total or complete ankyloglossia.

    e. Intraoral abscesses which extend beyond the dental alveolus.

    f. Extraoral abscesses.

    g. Cellulitis and osteitis which is clearly exacerbating and directly affecting a medical condition currently under treatment.

    h. Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.

    i. 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.