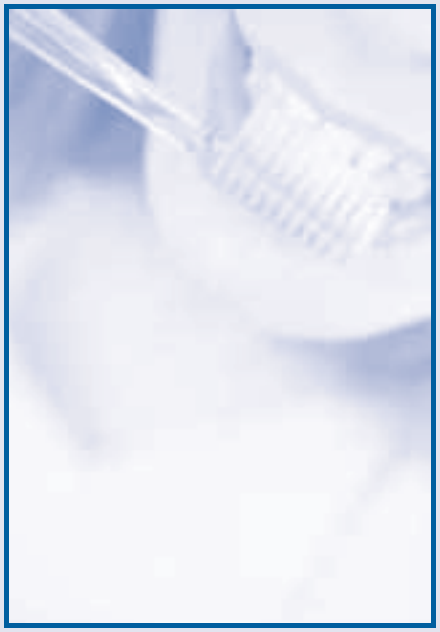
UNITED CONCORDIA
TRICARE DENTAL PROGRAM

Benefit Booklet



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TRICARE

UNITED CONCORDIA
TRICARE DENTAL PROGRAM

Dear Sponsor and Family Members,

Welcome to the **TRICARE Dental Program (TDP)**. As a member of the TDP, you can be assured you have a comprehensive dental plan that is equal to or better than many commercial dental plans.

This benefit booklet explains the TDP and provides you with information about eligibility, enrollment, premiums, cost shares, dentist participation, dental coverage, annual and orthodontic maximums, claim filing information, and policy benefits and limitations. The booklet also details information specific to active duty family members and to Selected Reserve and Individual Ready Reserve members and their family members.

Different policies exist if you receive dental care in the CONUS or OCONUS service area. The CONUS area (or "Continental United States") consists of the 50 United States, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. OCONUS (or "outside the Continental United States") includes all other global locations not previously listed. The OCONUS service area is further categorized into *non-remote* and *remote* locations. This booklet defines these areas as well as the procedures you need to follow to receive dental care and reimbursement. Be sure to review the appropriate sections of the benefit booklet to determine the policies that apply to you and your family.

If you receive dental care in the CONUS service area, you will get the greatest value from your TDP coverage by visiting a United Concordia participating dentist. These dentists will complete and submit your claims for you, submit predetermination requests when appropriate, and accept payment directly from United Concordia. The complete listing of dentists is available on our website: **www.ucci.com**.

In addition to this booklet, each enrolled member will receive a TDP Identification (ID) Card. Be sure to present your ID card to your dentist each time you visit his or her office.

If you have questions regarding the TDP, refer to the "Directory" section of this booklet for the appropriate telephone number and/or mailing address for your area.

We look forward to providing you with quality service.

Sincerely,

Thomas A. Harbold
Senior Vice President
TDP Dental Unit

TRICARE

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The TRICARE Dental Program

The TRICARE Dental Program (TDP) is offered by the Department of Defense (DoD) through the TRICARE Management Activity (TMA). United Concordia administers and underwrites the TDP for the TMA.

The TDP is a high quality, cost-effective dental care benefit for family members of all active duty Uniformed Service personnel and to Selected Reserve and Individual Ready Reserve (IRR) members and/or their families. The Uniformed Services include the Air Force, Army, Navy, Marine Corps, Coast Guard, National Oceanic and Atmospheric Administration, and Public Health Service.

Geographical Areas of Service

CONUS Service Area

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

OCONUS Service Area

The OCONUS, or "outside the Continental United States" service area includes all other countries, island masses, and territorial waters not in the CONUS service area. Covered services provided on a ship or vessel that is outside the territorial waters of the CONUS service area are covered under the OCONUS service area, regardless of the dentist's home address. The OCONUS service area is further categorized into non-remote and remote locations.

Non-remote OCONUS Locations

For purposes of the TDP, non-remote OCONUS locations are those OCONUS countries where the Uniformed Services have a fixed Overseas Dental Treatment Facility (ODTF). If Uniformed Service ODTFs are unable to provide specific services in non-remote countries, they may authorize enrolled members to receive covered dental services from host country dentists, subject to availability. Non-remote countries include:

Azores
Bahrain
Belgium
Diego Garcia
Germany
Iceland
Italy/Sardinia
Japan
Portugal
South Korea
Spain
Turkey
United Kingdom

For non-orthodontic services received in these locations, active duty family members must obtain a Non-Availability and Referral Form from their servicing ODTF and be seen by a dentist on the OCONUS Provider Listing. For orthodontic services, all enrollees must obtain a Non-Availability and Referral Form and be seen by a dentist on the OCONUS Provider Listing. These requirements must be met in order for United Concordia to issue payment for covered services.

Remote OCONUS Locations

Remote OCONUS locations are those OCONUS countries where the Uniformed Services do not have a fixed ODTF. This includes those countries that have "part-time" Uniformed Service ODTFs and no fixed ODTFs. Refer to the list of countries in the "Non-remote OCONUS Locations" section. All OCONUS countries not on this list are considered remote locations.

For non-orthodontic care, enrolled members may seek care from any dentist for covered services. A Non-Availability and Referral Form is not required for non-orthodontic care in remote locations; however, members are encouraged to use the OCONUS Provider Listing that may be available through their respective Overseas Lead Agents, U.S. Embassy or Consulate office or from other local representatives of the U.S. Government.

If the Overseas Lead Agent subsequently develops an OCONUS Provider Listing for specific remote locations, the member will be required to utilize dentists on these lists in order for claims for covered services to be considered for payment under the TDP.

For orthodontic care, all enrollees in remote OCONUS locations are required to have a Non-Availability and Referral Form, issued by the Overseas Lead Agent (or designee). Dental care must be provided by an orthodontist on the OCONUS Provider Listing. One exception is Canada, where members may receive care from any orthodontist; however, a Non-Availability and Referral Form is still required prior to obtaining treatment.

Eligibility

The TDP is available to family members of all active duty Uniformed Service personnel and to Selected Reserve and IRR members and/or their families. To be eligible for the TDP, the sponsor must have at least 12 months remaining on his or her service commitment with the parent Service at the time of enrollment. When the Defense Enrollment Eligibility Reporting System (DEERS) indicates less than 12 months remaining, United Concordia will validate the intent of those active duty, Selected Reserve, or IRR members to continue their service commitment. This service commit-

ment will be based on the time remaining in any single status or in any uninterrupted combination of active duty, Selected Reserve, or IRR status.

Note: *Any reservist who is on a tour of active duty that is greater than 30 days receives the same entitlements as an active duty member. This includes the Active Guard/ Reserve (AGR) and reservists on active duty for special work or training.*

Individuals eligible to enroll in the TDP include the following:

1) Family members of active duty, Selected Reserve, and IRR service members. This includes spouses and unmarried children (including stepchildren, adopted children, and wards) under the age of 21. Family members will be eligible up to the end of the month in which they turn 21. Family members may be eligible after age 21 if:

•They are enrolled full time at an accredited college or university and they are more than 50 percent dependent on the sponsor for financial support. These students are eligible to the end of the month in which they turn age 23. If the student terminates his or her education prior to turning 23, eligibility ends at the end of the month in which education terminates.

•They have a disabling illness or injury that occurred before their 21st birthday or between the ages of 21 and 23 if they were enrolled as a full time student at the time of the illness or injury, and they were more than 50 percent dependent on the sponsor for financial support.

2) Selected Reserve and IRR service members.

Note: *All enrollees are eligible for dental care in both CONUS and OCONUS service areas. The family member does not have to be command sponsored, listed on the sponsor's change of assignment orders, or formally recognized as a family member on an accompanied tour to receive dental care in the OCONUS service area.*

Verification of Eligibility

United Concordia verifies member eligibility through the Defense Enrollment Eligibility Reporting System (DEERS). It is extremely important that the DEERS contains up-to-date information on each family member. It is the sponsor's responsibility to ensure that all necessary updates are made to the DEERS, including, but not limited to:

- Adding or terminating entitlements for a spouse
- Adding or terminating entitlements for a child or ward
- Updating the sponsor's or family member's address
- Changing a name

If the information listed in the DEERS does not match the information provided on the enrollment application, enrollment in the TDP may be denied.

Note: *DEERS information can be verified and updated, if necessary, by contacting your nearest personnel office that has a Uniformed Services ID card facility. Sponsors or registered family members may make address changes; however, only sponsors can add or delete family members. A document such as a marriage certificate, divorce decree, or birth certificate must be presented when requesting such changes. If a Uniformed Service personnel office is not available, sponsors or registered family members may fax these documents to the DEERS Support Office at 1-831-655-8317. The sponsor's Social Security Number must be included with the faxed documents.*

Individuals Who Are Not Eligible for TDP Coverage

Active duty service members are not eligible for the TDP. This includes Selected Reserve and IRR members who are on active duty for more than 30 days. In addition, former spouses, parents, in-laws, disabled veterans, foreign personnel, and retirees and their families are not eligible for TDP benefits.

Enrollment Options

Enrollment in the TDP may be through a single or family plan. A Selected Reserve or IRR member is eligible to enroll under a single plan. Eligible family members are enrolled under a separate single or family plan.

A single enrollment is one covered eligible member. This includes one active duty family member, the Selected Reserve or IRR sponsor, or one Selected Reserve or IRR family member.

A family enrollment is two or more covered eligible family members. Examples are two or more active duty family members or two or more Selected Reserve or IRR family members.

Under the TDP, all eligible family members, must be enrolled if any one of them is enrolled with the following exceptions:

- Children under age four may be voluntarily enrolled. Upon reaching age four, children will be automatically

enrolled on the first day of the month following the month in which they reach age four. United Concordia will notify the sponsor of their enrollment.

• If a sponsor has family members residing in two or more locations, he or she may choose to enroll only the family members residing in one location. Examples of this include children who are attending college away from home or living with a divorced spouse.

• For active duty family members only, and in instances where a family member requires a hospital or special treatment environment (due to medical, physical handicap, or mental condition) for dental care otherwise covered by the TDP, the family member may be excluded from TDP enrollment and may continue to receive care from a military treatment facility. The sponsor must provide United Concordia with documentation of this situation.

• Selected Reserve and IRR sponsors must enroll independently of their family members. Also, Selected Reserve and IRR sponsors may enroll their family members and not themselves. If the sponsor chooses to enroll himself/herself in addition to the family member(s), there will be separate premium payments for each contract – one for the sponsor and one for the family member(s).

Note: *Members cannot be enrolled under two TDP contracts. Two service members cannot enroll the same family member(s). Additionally, in the instance that both the husband and wife are service members, two sponsors cannot enroll each other as beneficiaries.*

Enrollment Period

Regardless of previous enrollment, all new enrollees must remain enrolled in the TDP for at least 12 months. After completing the 12-month minimum enrollment period, enrollment may be continued on a month to month basis. Anyone who fails to pay premiums or disenrolls for other than a valid disenrollment reason (see "Disenrollment" section of this booklet) will be prohibited from re-enrolling in the program for 12 months.

Enrolling in the TDP

The enrollment process is handled by United Concordia. Enrollment must be initiated by the sponsor and is accomplished by completing a TDP Enrollment/Change Form. If the sponsor is not available to complete and sign the form, the individual with Power of Attorney can initiate enrollment, as long as a copy of a valid Power of Attorney is attached to the enrollment form.

Forms are available by calling United Concordia at **1-888-622-2256** to request a form, by accessing our website at **www.ucci.com** (under the TRICARE Dental Program tab, click on "Reference Materials"), or by visiting your local Uniformed Service personnel office, Dental Treatment Facility, or TRICARE Service Center (TSC). With the initial enrollment application, all new enrollees must submit a payment equal to the member's portion of one month's premium.

If any information is missing from the application, it will be returned to the sponsor. Once the requested information has been provided, enrollment can be processed. The application will be processed for the next available effective date.

On-line enrollment is also an option when using a credit card for the initial premium payment. You can access the on-line TDP Enrollment/Change Form at **www.ucci.com**. Click on the TRICARE Dental Program tab, then select "On-line Enrollment." Upon completion of the on-line enrollment process, a transaction number is provided. This number should be retained for future reference. Please note: The on-line enrollment option is for new contracts only. This option cannot be used to add/cancel a family member on an existing contract.

TDP-enrolled members who reside in the CONUS service area automatically have their enrollment and coverage extended to the OCONUS service area. Enrolled members relocating to the OCONUS service area are bound by OCONUS dental benefits program policies and procedures. Enrolled members residing in the CONUS service area, but who visit OCONUS countries, will be subject to the OCONUS dental benefits program procedures for processing claims.

Note: *Current Federal statute and regulations prohibit enrolled family members from receiving TDP-covered services in Uniformed Service Dental Treatment Facilities (DTFs). Exceptions to this prohibition include emergency treatment, dental care provided outside the U.S., and services incidental to non-covered services. Enrolled members may continue to obtain non-covered services from Uniformed Service DTFs based in CONUS subject to the provisions for space available care. In ODTFs, all family members, whether enrolled in the TDP or not, have the same eligibility status for care. However, access to care in ODTFs is based on the operational requirements of the active duty force serviced by the ODTF and the resources of that particular facility.*

Effective Date of Coverage

When United Concordia receives an enrollment application, a query will be made to the DEERS database to confirm eligibility. If eligibility is confirmed, the initial premium payment is received, and the application is complete, United Concordia will enroll the member(s) in the TDP. If the enrollment application and the initial payment are received by the 20th of the month, coverage will be processed for the first day of the following month. If the enrollment application and initial premium payment are received after the 20th of the month, coverage will be processed for the first day of the second month. For example: If the enrollment application and initial premium payment are received by February 20, coverage will be effective March 1. If the enrollment application and initial premium payment are received February 21, coverage will not be effective until April 1. Enrollment is processed according to the date of receipt, not by a post-marked date or the date on the application.

If eligibility cannot be confirmed by United Concordia, the member(s) will be notified and instructed to contact his or her Uniformed Service personnel office to resolve the issue. In this instance, coverage will not begin until the issue is resolved and eligibility can be verified.

It is strongly recommended that members contact United Concordia's Customer Service Department by telephone, before receiving initial treatment, to ensure coverage is in effect and to confirm the effective date of that coverage. Refer to the "Directory" section of this booklet for the appropriate telephone number for contacting United Concordia.

Evidence of Coverage

United Concordia will issue evidence of enrollment to all enrollees. All sponsors will receive a TDP Benefit Booklet. In addition, each enrolled member will receive a TDP Identification (ID) Card that should be presented at each dental office visit. Replacement ID cards can be requested by calling United Concordia's Enrollment and Billing Department at **1-888-622-2256** or by visiting United Concordia's website: **www.ucci.com**.

Disenrollment

New enrollees must remain enrolled in the TDP for a minimum of 12 months. Anyone who fails to pay premiums or disenrolls for other than a valid disenrollment reason during the initial 12-month enrollment period will be responsible for payment of all remaining premiums through the end of the initial 12-month enrollment period and will be prohibited from re-enrolling in the program, or "locked-out," for 12 months following the last month that premiums were paid.

The following are valid reasons for disenrolling from the TDP prior to completion of the mandatory 12-month period:

- When a sponsor or family member(s) loses DEERS eligibility due to death, divorce, marriage of a child, end of entitlement, or when a family member reaches age 21 (or 23 if enrolled at an accredited college or university).

- When TDP enrolled members relocate to areas within the OCONUS service area, the service members may elect (within 90 calendar days of the relocation) to disenroll their family members and/or themselves from the TDP. The date of the relocation must be included on the disenrollment request. Disenrollment will then be processed based on the date the TDP Enrollment/Change Form is received.

- When an active duty member transfers with enrolled family members to a duty station where space-available dental care for the enrolled members is readily available at the local Uniformed Service Dental Treatment Facility (DTF), the active duty member may elect (within 90 calendar days of the transfer) to disenroll his or her family members from the TDP. The date of the transfer must be included on the disenrollment request. Disenrollment will then be processed based on the date the TDP Enrollment/Change Form is received.

- When an active duty, Selected Reserve or IRR member is transferred to the Standby Reserve or Retired Reserve.

For the disenrollment situations listed below, United Concordia will notify the sponsor of this disenrollment. The notification will explain enrollment/disenrollment options and any associated premium changes and time limitations.

- If one member in a joint service marriage leaves the Uniformed Services and has family members assigned to him or her, the family members can be re-enrolled to the other service member. The enrollment under the new sponsor must be done within 30 calendar days of the disenrollment under the previous sponsor, in order to not incur a new 12-month lock-in period.

- When an active duty member transfers to the Reserve component (Selected Reserve, Guard/Reserve on active duty, or IRR). The enrolled family members are disenrolled from the TDP.

• When a member of the Reserve component (Selected Reserve, Guard/Reserve on active duty, or IRR) transfers to active duty. The enrolled family members will be disenrolled from the reserve plan and re-enrolled under an active duty plan. The appropriate premium rate change will apply.

If a Guard/Reserve sponsor on active duty changes to Selected Reserve status, the family will be automatically re-enrolled in a Selected Reserve plan. The appropriate premium rate change will apply.

• When the sponsor changes from one branch of service to another.

• When a Selected Reserve, Guard/Reserve on active duty, or IRR (Special Mobilization Category) member changes status to IRR (other than Special Mobilization Category). The enrolled member and/or family members are disenrolled from their current plan and automatically re-enrolled into an IRR coverage plan. The enrolled member/family members may elect to disenroll from the TDP, if desired.

• When a Selected Reserve or IRR member is called to active duty for greater than 30 days. The sponsor and the family member(s) are disenrolled. The family member(s) will be automatically re-enrolled in the program at the lower active duty premium rate and will continue under the existing 12-month lock-in period. When the sponsor returns to Selected Reserve or IRR status, his or her coverage will be reinstated and begin on the first day of the month after the status change. The sponsor will be responsible for completing the remaining months on his or her 12-month lock-in period. The premium rate of the family member(s) will return to the appropriate reservist rate.

• If a sponsor is called to active duty in support of a contingency operation and enrolls his or her family members within 30 days of the active duty start date, coverage may be terminated when the active duty commitment ends. In these cases, the sponsor must initiate the disenrollment by completing a TDP Enrollment/Change Form. The sponsor's active duty start date must be indicated on the form.

In all instances listed above in which the contract is canceled and re-enrollment is not automatic, the sponsor must re-enroll within 30 days of cancellation to prevent a lapse in coverage and continue the original lock-in period.

Disenrollment is not automatic. Once enrollees meet their 12-month lock-in period, or if they have a valid disenrollment reason, they may choose to disenroll from the TDP. Disenrolling requires submission of a TDP Enrollment/Change Form, signed by the sponsor. If the sponsor is not available to sign the form, the individual with Power of Attorney may sign the form as long as a copy of a valid Power of Attorney is attached. If the form is received by the 20th of the month, the cancellation will be processed for the first day of the following month. If the form is received after the 20th of the month, the cancellation will be processed for the first day of the second month.

End of Coverage

The following are situations that result in a change in the member's status. The end dates of coverage for each are as follows:

• If the sponsor's retirement or separation is on the first day of the month, the last day of coverage is the last day of the previous month. For example: If the sponsor retires on February 1, the last day of coverage is January 31.

• When a child reaches age 21 (or age 23 if full time at an accredited college or university), the child loses eligibility as of 11:59 p.m. on the last day of the month in which the age limit is reached. For example: If a child turns 21 on March 15, the last day of coverage is March 31.

• In a divorce situation, the spouse loses all eligibility based on his or her former marital status as of 11:59 p.m. on the last day of the month in which the divorce becomes final. For example: If the divorce is final on March 5, the last day of coverage is March 31.

TDP Survivor Benefits

When an enrolled active duty service member dies while on active duty for a period of more than 30 days, the enrolled family members will continue to receive TDP benefits for three years from the month following the month of the member's death as long as the family members were enrolled at the time of the member's death.

The survivor benefit also applies to enrolled family members of Selected Reserve and IRR (Special Mobilization Category) sponsors who die while in Selected Reserve and IRR (Special Mobilization Category) status, regardless if the sponsor was enrolled at the time of his or her death.

In these cases, the Government will pay 100 percent of the TDP premium. United Concordia will track the three-

year period and notify family members of coverage termination prior to disenrollment.

Premiums

For active duty family members and for Selected Reserve and IRR (Special Mobilization Category only) members, the Government pays part of the monthly premium. IRR (other than Special Mobilization Category) members and all Selected Reserve and IRR family members are responsible for the full amount of the premium cost. If the sponsor's military status changes, the premium changes accordingly. The following chart provides a summary of TDP premium shares:

ENROLLEE CATEGORY	PREMIUM SHARE
Active Duty Family Members	60% Government 40% Enrollee
Selected Reserve and IRR (Special Mobilization Category) Members	60% Government 40% Enrollee
IRR (other than Special Mobilization Category) Members	100% Enrollee
Selected Reserve and IRR Family Members	100% Enrollee

Premiums are paid for a full month of coverage. There are no circumstances when a partial premium can be paid.

If the member fails to pay premiums (or disenrolls for an invalid reason), the Government will not pay any portion of the premium (Government or member share) for the remaining months. United Concordia will collect the full amount, both Government and member share, of any remaining premium due for the enrollment period from the member. Failure to pay the required premiums may result in referral of the account to a collection agency.

Premium Payroll Allotments

If the member has a payroll account, and if sufficient funds are available at the time of collection, the Government will collect the member's share of the premium, in advance, through a Uniformed Service Finance Center. Only premiums for active duty family members and Selected Reserve sponsors may be taken from the sponsor's payroll account. All other premiums must be paid directly to United Concordia by the member. Members should always verify that the correct dental deduction appears on their Leave and Earnings Statement (LES).

If United Concordia is unable to obtain the requested premium payment from the sponsor's payroll account for any reason, the member will be responsible for paying the premium costs by means of direct billing. When this occurs, premium collection will transfer from the Uniformed Service Finance Center payroll allotment or deduction to direct billing by United Concordia.

Direct Billing Process

If the member is set up for direct billing, United Concordia will issue a monthly invoice to collect the member's premium. If the sponsor and family member(s) are both enrolled and on direct billing, two monthly invoices will be issued.

United Concordia will automatically direct bill for premiums due from IRR service members and from Selected Reserve and IRR family members.

Maximums

The TDP limits how much can be paid for any member's dental services. The annual maximum payment is $1,200 per enrollee per contract year, for non-orthodontic services. **Each contract year begins February 1 and ends January 31 the following year.** This means that the total payments for covered dental services, except orthodontics, for each enrolled member will not exceed $1,200 in any contract year. Payment for certain diagnostic and preventive services are not applied against the annual maximum. (Refer to the "TDP Benefits" section for those specific procedures.)

There is a lifetime maximum of $1,500 per member for orthodontic treatment. If a member receives orthodontic services, payments for these services will not exceed $1,500 during the member's eligibility lifetime. Orthodontic diagnostic services will be applied to the $1,200 annual maximum. (Refer to the "TDP Benefits" section for more information.)

The maximums for the OCONUS service area are the same as the CONUS service area for orthodontics and other dental services. The accumulation of charges against the annual maximum and lifetime orthodontic maximum is based on the allowable charges less any cost shares. The allowable charge is the amount that United Concordia will pay for any procedure and the cost share is the portion of the allowed amount that the member must pay. Additionally, the member's cost shares are not charged against the annual and lifetime maximums.

In the OCONUS service area, the Government will pay for any costs in excess of United Concordia's fee allowance up to the billed charge for all enrollees except Selected Re-

serve and IRR family members and IRR (other than Special Mobilization Category) members. The Government will not pay for the portion of the member's maximum that has already been paid by United Concordia nor will the Government pay for any costs once the maximum has been met.

Cost Shares

United Concordia will pay a percentage of the dentist's usual charge up to United Concordia's allowance for the service, subject to limitations and non-covered services. The percentage paid and the member's cost share depend on the type of service received. For example: Preventive services (such as cleanings and fluoride treatments) are paid at 100 percent of United Concordia's allowance, with no member cost share; however, basic restorative services (such as fillings) are covered at 80 percent, with a 20 percent member cost share.

Dentists are required to collect cost shares for covered services. Failure to collect cost shares for covered services could disqualify the dentist from participating in United Concordia's dentist network.

Cost Share Exceptions

The following are exceptions to the member's cost share:

- In the OCONUS service area, the Government will pay active duty family members' and Selected Reserve and IRR (Special Mobilization Category) members' cost shares for all services except orthodontic, prosthodontic, and other restorative services; members are not required to pay this amount. The Government will not pay cost shares for any services received in the CONUS service area regardless of whether or not the member is returning to the CONUS service area on a permanent or temporary basis.

- Although OCONUS coverage is available for Selected Reserve and IRR family members and for IRR (other than Special Mobilization Category) members, the Government will not pay for any cost shares for these populations. All cost shares are the responsibility of the sponsor/family member.

Cost Shares Summary Chart

The following chart provides an overview of the member's cost shares for types of services covered under the TDP. **Please note that the TDP provides selected services at a reduced cost share for members who are grades E-1 to E-4. These include endodontic, periodontic, and oral surgery services.**

TYPE OF SERVICE	PAY GRADES E-1 TO E-4 CONUS	ALL OTHER PAY GRADES CONUS	OCONUS*
Diagnostic	0%	0%	0%
Preventive (except sealants)	0%	0%	0%
Emergency Services	0%	0%	0%
Sealants	20%	20%	0%
Basic Restorative	20%	20%	0%
Endodontic	30%	40%	0%
Periodontic	30%	40%	0%
Oral Surgery	30%	40%	0%
Other Restorative	50%	50%	50%
Prosthodontic	50%	50%	50%
Orthodontic	50%	50%	50%
General Anesthesia	40%	40%	0%
Intravenous Sedation	50%	50%	0%
Consultation/Office Visit	20%	20%	0%
Medication	50%	50%	0%
Post Surgical Services	20%	20%	0%
Miscellaneous Services (occlusal guard, athletic mouthguard, bleaching)	50%	50%	0%

**Selected Reserve and IRR family members and IRR (other than Special Mobilization Category) members will be responsible for the applicable cost share portion regardless if treatment is received CONUS or OCONUS. The Government will not pay any cost shares for these populations.*

TDP Benefits

TDP benefits, limitations, and exclusions are the same for both CONUS and OCONUS service areas. In certain circumstances, some covered services may be unavailable from OCONUS host nation dentists due to that country's standards of dental practice. In these cases, United Concordia will exercise reasonable judgement to accommodate unusual circumstances relevant to the practice and delivery of dental services in the OCONUS service area and to consider payment in these cases.

General Policies

All covered services are subject to the following general policies:

• Services must be necessary and meet accepted standards of dental practice. Services determined to be unnecessary or which do not meet accepted standards of dental practice are not billable to the patient by a participating dentist unless the dentist notifies the patient of his/her liability prior to treatment and the patient chooses to receive the treatment. Participating dentists should document such notification in their records.

• An appeal is not available when the services are determined to be unnecessary or do not meet accepted standards of dental practice unless the dentist notifies the patient of his/her liability prior to treatment and the patient chooses to receive the treatment. This is because such services are not billable to the patient, and there would be no amount in dispute to consider at appeal.

• Medical procedures as well as procedures covered as adjunctive dental care under TRICARE/Medical are not covered under the TDP.

• Procedures should be reported using the American Dental Association's (ADA) current dental procedure codes and terminology. If a procedure code is not given, a complete description of the service performed, including applicable tooth numbers, should be provided.

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

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

• Participating dentists may not bill United Concordia or the member for the completion of claim forms and submission of required information for determination of benefits.

• 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 participating dentist.

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

• Payment for diagnostic services performed in conjunction with orthodontics is applied to the member's annual maximum, subject to the note under "Diagnostic Services."

• 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 February to January contract year. For example: If a member enrolls in the TDP in March 2001 and receives a cleaning May 13, 2001 and then again November 10, 2001, he or she would be eligible for the next cleaning May 1, 2002. If the member chooses to have a cleaning in March 2002, that would be the third cleaning within a 12 consecutive month period and would not be an allowable charge. The third cleaning in a 12-month period would not be covered since it is in excess of the two allowable cleanings in a 12 consecutive month period.

• 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. For example: If scaling and root planing was performed on September 10, 1999, scaling and root planing in the same area of the mouth would not be eligible until September 10, 2001.

• The 36-month time limitation for a panoramic or complete series of x-rays or a denture reline/rebase is calculated to the month in which the service was performed. For example: If a member received a complete series of x-rays on May 15, 1999, he or she would be eligible for another complete series of x-rays or a panoramic x-ray on May 1, 2002.

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

• The five-year time limitation for other restorative services (e.g., crowns, onlays, etc.) and prosthodontic services (e.g., dentures, fixed bridges, etc.), is based on the exact date of service (day and month) when the procedure was performed. For example: If a fixed partial

denture were placed on June 15, 1997, a replacement denture would not be eligible until June 15, 2002.

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

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

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

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

If you have any questions about benefit periods and eligibility, please contact a Customer Service Representative before obtaining the service.

Covered Services

Diagnostic Material Requirements and "By Report" 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, dentists are requested to submit all x-rays used for diagnosis and treatment planning.

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

"Report required" means that these services will be paid only in unusual 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: *For OCONUS claims, the submission of x-rays and periodontal charting is not required unless specifically requested by United Concordia. All claims received from the OCONUS service area will be processed without a "report" requirement.*

Diagnostic Services

R=Report required

Code	Description of Service
D0120*	Periodic oral evaluation
D0140	Limited oral evaluation - problem focused
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 (including bitewings)
D0220*	Intraoral - periapical first film
D0230*	Intraoral - periapical - each additional film
D0240*	Intraoral - occlusal film
D0250	Extraoral - first film
D0260	Extraoral - each additional film
D0270*	Bitewing - single film
D0272*	Bitewings - two films
D0274*	Bitewings - four films
D0277	Vertical bitewings - 7 to 8 films
D0290	Posterior-anterior or lateral skull and facial bone survey film
D0330* R	Panoramic film
D0340	Cephalometric film
D0425*	Caries susceptibility tests

Notes: *The annual payment maximum is not affected by those services identified with an asterisk (*).*

Patient specific rationale (specific signs or symptoms) is required when submitting a claim for a panorex for a patient under age 5.

Benefits and Limitations for Diagnostic Services

• Three oral evaluations (D0120, D0150 and D0180) are covered in a 12 consecutive month period. Only two of these oral evaluations may be from the same office. However, a third oral evaluation is covered only if it is provided by a different office.

• Only two comprehensive evaluations (D0150) will be allowed in a 12 consecutive month period. However, only one comprehensive evaluation (D0150) will be allowed per patient per dentist in a 12 consecutive month period.

• Only one comprehensive periodontal evaluation (D0180) will be allowed per patient per 24 consecutive month period. 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.

• Only one limited oral evaluation, problem-focused (D0140) will be allowed per patient per dentist in a 12 consecutive 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.

• Re-evaluations are considered integral procedures.

• Detailed and extensive oral evaluations (problem-focused) are only payable by report upon advisor review and are limited to one per patient per dentist, per lifetime. They will not be paid if related to non-covered medical, dental, or adjunctive dental procedures.

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

• One complete series of x-rays or one panoramic x-ray is covered in a 36-month period.

• Panoramic x-rays are not routinely covered for patients under age five unless approved by a United Concordia Dental Advisor. Patient specific rationale (specific signs or symptoms) must be submitted for review.

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

• A second set of bitewing x-rays, consisting of up to four bitewing x-rays per visit, is covered at the gaining location if the member 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.

• 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.

• Periapical x-rays are covered, when necessary.

• X-rays are not a covered benefit when taken by an x-ray laboratory, unless billed by a licensed dentist.

• 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 reported x-rays are paid as a complete series and are subject to the same benefit limitations as a complete series. Any difference in fees may not be charged to the member by a participating dentist.

• 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.

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

• 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.

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

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

• Pulp vitality tests are considered integral to all services.

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

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

Preventive Services

Member cost share percentages may vary depending on the sponsor's pay grade and location (CONUS or OCONUS). Refer to the "Cost Shares Summary Chart" for the applicable cost share amount for your specific situation.

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

Code	Description of Service
D1110*	Prophylaxis - adult
D1120*	Prophylaxis - child
D1201*	Topical application of fluoride (including prophylaxis) - child
D1203*	Topical application of fluoride (excluding prophylaxis) - child
D1204*	Topical application of fluoride (excluding prophylaxis) - adult
D1205*	Topical application of fluoride (including prophylaxis) - adult
D1510	Space maintainer - fixed - unilateral
D1515	Space maintainer - fixed - bilateral
D1520	Space maintainer - removable - unilateral
D1525	Space maintainer - removable - bilateral
D1550	Recementation of space maintainer

Note: *The annual payment maximum is not affected by those services identified with an asterisk (*).*

Benefits and Limitations for Preventive Services

- Two routine prophylaxes are covered in a 12 consecutive month period.
- Adult prophylaxes will be allowed on patients 13 years of age and older.
- Routine prophylaxes are considered integral when performed by the same dentist on the same day as scaling and root planing, periodontal surgery, and periodontal maintenance procedures.
- A routine prophylaxis is considered integral when performed in conjunction with or as a finishing procedure to periodontal scaling and root planing, periodontal maintenance, gingivectomy or gingivoplasty, gingival flap procedure, mucogingival surgery or osseous surgery.
- A routine prophylaxis includes associated scaling and polishing procedures. There are no provisions for any additional allowance based on degree of difficulty.
- Periodontal scaling in the presence of gingival inflammation is considered to be a routine prophylaxis and is paid as such. Participating dentists may not bill the patient for any difference in fees.
- Two topical fluoride applications are covered in a 12 consecutive month period.
- Topical fluoride applications are covered only when performed using an ADA accepted topical fluoride held in close proximity to the teeth through means of intraoral trays. The use of fluoride rinse or 'swish' does not qualify as a benefit and should not be reported under the fluoride codes as a fluoride treatment. The use of a prophylaxis paste containing fluoride qualifies for payment only as a routine prophylaxis.
- Space maintainers are fully covered for members under the age of 19 when replacing primary cuspids, primary molars, and permanent first molars.
- Space maintainers are also covered for members under the age of 19 when replacing incisors only or a combination of incisors and other eligible teeth. However when provided for this purpose, the member will be responsible for a 20% cost share.
- Repair of a damaged space maintainer is not a covered benefit.
- Removal of a space maintainer is not a covered benefit, unless performed by a different dentist who is also not a member of the same practice.

Sealants

Member cost share percentages may vary depending on the sponsor's pay grade and location (CONUS or OCONUS). Refer to the "Cost Shares Summary Chart" for the applicable cost share amount for your specific situation.

Code	Description of Service
D1351	Sealant - per tooth

Benefits and Limitations for Sealants

- Sealants are covered on permanent bicuspids and permanent molars through age 18. The teeth must be caries free with no previous restoration on the mesial, distal, or occlusal surfaces. One sealant per tooth is covered in a three-year period.
- Sealants for teeth other than permanent bicuspids and permanent molars are not covered.
- Sealants provided on the same date of service and the same tooth as a restoration of the occlusal surface are considered integral procedures.

Restorative Services

Member cost share percentages may vary depending on the sponsor's pay grade and location (CONUS or OCONUS). Refer to the "Cost Shares Summary Chart" for the applicable cost share amount for your specific situation.

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
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

• Diagnostic casts (study models) taken in conjunction with restorative procedures are considered integral.

• Sedative restorations are not a covered benefit.

• Pin retention is covered only when reported in conjunction with an eligible restoration.

• An amalgam or resin restoration reported with a pin (D2951), in addition to a crown, is considered to be a pin buildup (D2950 or D6973).

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

• Restorative services are covered only when necessary due to decay or tooth fracture. Restorative services are not benefits when performed for cosmetic purposes or due to attrition, erosion, abrasion, or congenital or developmental defects.

• A restoration involving two or more surfaces should be reported using the appropriate multiple surface restoration code.

• 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.

• 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.

• 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.

• Repair or replacement of restorations by the same dentist and involving the same tooth surfaces, performed within 24 months of the original restoration are considered integral procedures, and a separate fee is not chargeable to the member by a participating 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.

• Resin (composite) restorations 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 United Concordia for the amalgam restoration.

• 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 a United Concordia Dental Advisor.

• 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.

• 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 participating dentist.

• 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.

• 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.

• 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.

Other Restorative Services

Member cost share percentages may vary depending on the sponsor's pay grade and location (CONUS or OCONUS). Refer to the "Cost Shares Summary Chart" for the applicable cost share amount for your specific situation.

X=X-ray required
R=Report required

Code	Description of Service
D2542 X	Onlay - metallic - two surfaces
D2543 X	Onlay - metallic - three surfaces
D2544 X	Onlay - metallic - four or more surfaces
D2642 X	Onlay – porcelain/ceramic – two surfaces
D2643 X	Onlay – porcelain/ceramic – three surfaces
D2644 X	Onlay – porcelain/ceramic – four or more surfaces
D2662 X	Onlay – resin-based composite – two surfaces
D2663 X	Onlay – resin-based composite – three surfaces
D2664 X	Onlay – resin-based composite – four or more surfaces
D2740 X	Crown - porcelain/ceramic substrate
D2750 X	Crown - porcelain fused to high noble metal
D2751 X	Crown - porcelain fused to predominately base metal
D2752 X	Crown - porcelain fused to noble metal
D2780 X	Crown - 3/4 cast high noble metal
D2781 X	Crown - 3/4 cast 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
D2910	Recement inlay
D2920	Recement crown
D2950 X	Core buildup, including any pins
D2954 X	Prefabricated post and core in addition to crown
D2962 R	Labial veneer - porcelain laminate - laboratory
D2970 R	Temporary crown (fractured tooth)
D2980 R	Crown repair, by report

Benefits and Limitations for Other Restorative Services

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

• 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.

• 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 a United Concordia Dental Advisor.

• Core buildups (D2950) can be considered for benefits only when there is insufficient retention for a crown. A buildup should not be reported when the procedure only involves a filler used to eliminate undercuts, box forms or concave irregularities in the preparation.

• Cast 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 cast post and core and the amount paid by United Concordia for the prefabricated post and core.

• 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 (day and month) of the initial service versus the first day of the initial service month.

• 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.

• 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.

• Implant related restorative services are not covered.

• Temporary crowns (D2970) are generally not covered except in the following situations:

  • The tooth is fractured as the result of accidental injury.

  • The crown is placed on a permanent tooth for members 14 years of age or younger.

  • A crown is placed on a primary tooth.

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

• One temporary crown per tooth per lifetime is covered.

• Recementation of prefabricated and cast crowns, bridges, onlays, inlays, and posts is eligible once per six-month period. Recementation provided within 12 months of placement by the same dentist is considered integral.

• 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.

• 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.

• Porcelain veneers (D2962) can be considered for coverage for fully erupted anterior teeth to correct severe developmental or congenital disfigurement. A report must be submitted which describes the disfigurement. If approved, payment will be limited to once per tooth per five-year period.

• If veneers are placed in situations not involving severe developmental or congenital disfigurement, they are not covered. However, if a restoration is necessary due to tooth fracture or decay, payment may be made for an anterior resin restoration towards the cost of the veneer, and the member is responsible for any difference between this amount and the dentist's charge.

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

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

Endodontic Services

Member cost share percentages may vary depending on the sponsor's pay grade and location (CONUS or OCONUS). Refer to the "Cost Shares Summary Chart" for the applicable cost share amount for your specific situation.

X=X-ray Required
R=Report required

Code	Description of Service
D3120	Pulp cap - indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration)
D3221	Pulpal debridement - primary and permanent teeth
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)

D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)
D3310	Anterior root canal (excluding final restoration)
D3320	Bicuspid root canal (excluding final restoration)
D3330	Molar root canal (excluding final restoration)
D3332 XR	Incomplete endodontic therapy; inoperable or fractured tooth
D3333 XR	Internal root repair of perforation defects
D3346	Retreatment of previous root canal therapy - anterior
D3347	Retreatment of previous root canal therapy - bicuspid
D3348	Retreatment of previous root canal therapy - molar
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352	Apexification/recalcification - interim medication replacement (apical closure/ calcific repair of perforations, root resorption, etc.)
D3353	Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/ calcific repair of perforations, root resorption, etc.)
D3410	Apicoectomy/periradicular surgery - anterior
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)
D3425	Apicoectomy/periradicular surgery - molar (first root)
D3426	Apicoectomy/periradicular surgery (each additional root)
D3430	Retrograde filling - per root
D3450	Root amputation - per root
D3920	Hemisection (including any root removal) - not including root canal therapy

Benefits and Limitations for Endodontic Services

- Direct pulp caps are considered an integral service when provided on the same date as a restoration.
- 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.
- Pulpotomies are considered integral when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
- 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.
- Pulpal therapy (resorbable filling) is limited to primary teeth only and is a benefit once per tooth per lifetime. Payment for the pulpal therapy will be offset by the allowance for a pulpotomy provided within 45 days preceding pulpal therapy on the same tooth by the same dentist.
- Pulpal debridement is considered integral to root canal therapy or palliative emergency treatment when provided on the same day by the same dentist.
- Pulpal therapy (resorbable filling) is a benefit for primary incisor teeth for members up to age six and for primary molars and cuspids to age 11.
- Treatment of a root canal obstruction is considered an integral procedure.
- 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.
- Internal root repair of a perforation defect is not a covered benefit when the perforation is caused by the dentist providing the treatment. All other circumstances require a pre-treatment x-ray and a report.
- 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.
- For reporting and benefit purposes, the completion date for endodontic therapy is the date the tooth is sealed.
- Placement of a final restoration following endodontic therapy is eligible as a separate procedure.

Periodontal Services

Member cost share percentages may vary depending on the sponsor's pay grade and location (CONUS or OCONUS). Refer to the "Cost Shares Summary Chart" for the applicable cost share amount for your specific situation.

X=X-ray required
C=Periodontal charting required

Code	Description of Service
D4210 XC	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces, per quadrant
D4211 XC	Gingivectomy or gingivoplasty – one to three teeth, per quadrant
D4240 XC	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces, per quadrant
D4241 XC	Gingival flap procedure, including root planing – one to three teeth, per quadrant
D4249	Clinical crown lengthening - hard tissue
D4260 XC	Osseous surgery (including flap entry and closure) four or more contiguous teeth or bounded teeth spaces, per quadrant
D4261 XC	Osseous surgery (including flap entry and closure) – one to three teeth, per quadrant
D4263 X	Bone replacement graft - first site in quadrant
D4264 X	Bone replacement graft - 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
D4271 C	Free soft tissue graft procedure (including donor site surgery)
D4273 C	Subepithelial connective tissue graft procedures (including donor site surgery)
D4275 C	Soft tissue allograft
D4276 C	Combined connective tissue and double pedicle graft
D4341	Periodontal scaling and root planing – four or more contiguous teeth or bounded teeth spaces, per quadrant. See “Note” below.
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant. See “Note” below.
D4910	Periodontal maintenance
D4920	Unscheduled dressing change (by someone other than treating dentist)

Note: *X-rays and periodontal charting are required when submitting a claim for periodontal scaling and root planing (D4341) for members under the age of 19.*

Benefits and Limitations for Periodontal Services

- 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.
- 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.
- Surgical periodontal procedures or scaling and root planing in the same area of the mouth within 24 months of a gingival flap procedure are not covered.
- Gingival flap procedure is considered integral when provided on the same date of service by the same dentist in the same area of the mouth as periodontal surgical procedures, endodontic procedures and oral surgery procedures.
- Soft tissue grafts are processed according to the number of separate sites involved. Separate sites generally must be separated by two or more teeth.
- Subepithelial connective tissue grafts and combined connective tissue and double pedicle grafts are payable at the level of free soft tissue grafts. The difference between the allowance for the soft tissue graft and the dentist’s charge is the patient’s responsibility.
- A single site for reporting osseous 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. Non-contiguous areas involving different teeth may be reported as additional sites.
- Bone replacement grafts are eligible when provided to treat periodontal defects. They are not eligible when provided for other reasons such as filling in an extraction site or a defect resulting from an apicoectomy or cyst removal.
- Osseous surgery is not covered when provided within 24 months of osseous surgery in the same area of the mouth.
- 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, will be processed as crown lengthening.
- Guided tissue regeneration is covered only when provided to treat Class II furcation involvement or interbony defects. It is not covered when provided to obtain root coverage, or when provided in conjunction with extractions, cyst removal or procedures involving the removal of a portion of a tooth, e.g., apicoectomy or hemisection.

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

• Periodontal scaling and root planing is indicated to treat periodontal disease, which generally does not occur with frequency in younger patients. Periodontal scaling and root planing submitted for members under the age of 19 should be accompanied by x-rays and periodontal charting.

• 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.

• 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.

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

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

• 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.

• 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.

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

• Full mouth debridement to enable comprehensive evaluation and diagnosis is not a covered benefit. When performed on the same date of service as scaling and root planing, periodontal maintenance procedures, or a routine prophylaxis, it is considered integral to these services.

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

Oral Surgery Services

Member cost share percentages may vary depending on the sponsor's pay grade and location (CONUS or OCONUS). Refer to the "Cost Shares Summary Chart" for the applicable cost share amount for your specific situation.

X=X-ray required
R=Report required

Code	Description of Service
D7111	Coronal remnants – deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth - soft tissue
D7230 X	Removal of impacted tooth - partially bony
D7240 X	Removal of impacted tooth - completely bony
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280	Surgical access of an unerupted tooth
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption
D7285	Biopsy of oral tissue – hard (bone, tooth)
D7286	Biopsy of oral tissue – soft (all others)
D7290	Surgical repositioning of teeth
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report
D7310	Alveoloplasty in conjunction with extractions - per quadrant
D7320	Alveoloplasty not in conjunction with extractions - per quadrant
D7471	Removal of lateral exostosis - (maxilla or mandible)
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7485	Surgical reduction of osseous tuberosity
D7510	Incision and drainage of abscess - intraoral soft tissue
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
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity

Benefits and Limitations for Oral Surgery Services

- Fiberotomies are only covered on permanent first bicuspids and permanent anterior teeth.
- Simple incision and drainage reported with root canal therapy is considered integral to the root canal therapy.
- 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.
- Biopsies are an eligible benefit when tissue is surgically removed for the specific purpose of histopathological examination and diagnosis.
- Biopsies are considered integral when performed in conjunction with other surgical procedures on the same day in the same area of the mouth.
- 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.
- Routine postoperative care such as suture removal is considered integral to the fee for the surgery.
- The removal of impacted teeth is paid based on the anatomical position as determined from a review of x-rays. If the degree of impaction is determined to be less than the reported degree, payment will be based on the allowance for the lesser level.
- 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 a United Concordia Dental Advisor.
- An alveoloplasty performed in conjunction with extractions (code D7319) involving less than four teeth is not covered as a separate procedure. A fee cannot be charged to the patient by a participating dentist.

Prosthodontics, Removable

Member cost share percentages may vary depending on the sponsor's pay grade and location (CONUS or OCONUS). Refer to the "Cost Shares Summary Chart" for the applicable cost share amount for your specific situation.

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 any conventional clasps, rests and teeth)
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)
D5213	Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5214	Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5410	Adjust complete denture - maxillary
D5411	Adjust complete denture - mandibular
D5421	Adjust partial denture - maxillary
D5422	Adjust partial denture - mandibular
D5510	Repair broken complete denture base
D5520	Replace missing or broken teeth - complete denture – (each tooth)
D5610	Repair resin denture base
D5620	Repair cast framework
D5630	Repair or replace broken clasp
D5640	Replace broken teeth - per tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)
D5710	Rebase complete maxillary denture
D5711	Rebase complete mandibular denture
D5720	Rebase maxillary partial denture
D5721	Rebase mandibular partial denture
D5730	Reline complete maxillary denture (chairside)
D5731	Reline complete mandibular denture (chairside)
D5740	Reline maxillary partial denture (chairside)
D5741	Reline mandibular partial denture (chairside)
D5750	Reline complete maxillary denture (laboratory)
D5751	Reline complete mandibular denture (laboratory)
D5760	Reline maxillary partial denture (laboratory)
D5761	Reline mandibular partial denture (laboratory)
D5810	Interim complete denture (maxillary)
D5811	Interim complete denture (mandibular)
D5820	Interim partial denture (maxillary)
D5821	Interim partial denture (mandibular)
D5850	Tissue conditioning (maxillary)
D5851	Tissue conditioning (mandibular)

Prosthodontics, Fixed

Member cost share percentages may vary depending on the sponsor's pay grade and location (CONUS or

OCONUS). Refer to the "Cost Shares Summary Chart" for the applicable cost share amount for your specific situation.

X=X-ray required
R=Report required

Code	Description of Service
D6210 X	Pontic - cast high noble metal
D6211 X	Pontic - cast predominately base metal
D6212 X	Pontic - cast noble metal
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
D6245 X	Pontic - porcelain/ceramic
D6545 X	Retainer - cast metal for resin bonded fixed prosthesis
D6548 X	Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6600 X	Inlay - porcelain/ceramic, two surfaces
D6601 X	Inlay – porcelain/ceramic, three or more surfaces
D6602 X	Inlay - cast high noble metal, two surfaces
D6603 X	Inlay - cast high noble metal, three or more surfaces
D6604 X	Inlay - cast predominantly base metal, two surfaces
D6605 X	Inlay - cast predominantly base metal, three or more surfaces
D6606 X	Inlay - cast noble metal, two surfaces
D6607 X	Inlay - cast noble metal, three or more surfaces
D6608 X	Onlay – porcelain/ceramic, two surfaces
D6609 X	Onlay – porcelain/ceramic, three or more surfaces
D6610 X	Onlay - cast high noble metal, two surfaces
D6611 X	Onlay – cast high noble metal, three or more surfaces
D6612 X	Onlay – cast predominantly base metal, two surfaces
D6613 X	Onlay – cast predominantly base metal, three or more surfaces
D6614 X	Onlay – cast noble metal, two surfaces
D6615 X	Onlay – cast noble metal, three or more surfaces
D6740 X	Crown - porcelain/ceramic
D6750 X	Crown - porcelain fused to high noble metal
D6751 X	Crown - porcelain fused to predominately base metal
D6752 X	Crown - porcelain fused to noble metal
D6780 X	Crown - 3/4 cast high noble metal
D6781 X	Crown - 3/4 cast predominately base metal
D6782 X	Crown - 3/4 cast noble metal
D6783 X	Crown - 3/4 porcelain/ceramic
D6790 X	Crown - full cast high noble metal
D6791 X	Crown - full cast predominately base metal
D6792 X	Crown - full cast noble metal
D6930	Recement fixed partial denture
D6970 X	Cast post and core in addition to fixed partial denture retainer
D6972 X	Prefabricated post and core in addition to fixed partial denture retainer
D6973 X	Core buildup for retainer, including any pins
D6980 R	Fixed partial denture repair, by report

Benefits and Limitations for Prosthodontic Services

- For reporting and benefit purposes, the completion date for crowns and fixed partial dentures is the cementation date. The completion date is the insertion date for removable prosthodontic appliances.

- 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 participating dentist.

- 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 a United Concordia Dental Advisor.

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

- Recementation of crowns, fixed partial dentures, inlays, onlays, or cast posts within six months of their placement by the same dentist is considered integral to the original procedure.

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

- The relining or rebasing of a denture is considered integral when performed within six months following the insertion of that denture.

- A reline/rebase is covered once in any 36 months.

- 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 a United Concordia Dental Advisor.

- Payment for a denture or an overdenture made with precious metals is based on the allowance for a conven-

tional denture. Any additional cost is the member's responsibility.

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

• A fixed partial denture and removable partial denture are not covered benefits in the same arch. Payment will be made for a removable partial denture to replace all missing teeth in the arch.

• Cast unilateral removable partial dentures are not covered benefits.

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

• 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.

• Implant related prosthetics are not covered.

• Replacement of removable prostheses (D5110 through D5214) and fixed prostheses (D6210 through D6792) is covered only if the existing removable and/or fixed prostheses 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 (day and month) of the initial service versus the first day of the initial service month.

• 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.

• 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.

Orthodontic Services

Member cost share percentages may vary depending on the sponsor's pay grade and location (CONUS or OCONUS). Refer to the "Cost Shares Summary Chart" for the applicable cost share amount for your specific situation.

Code	Description of Service
D0470	Diagnostic Casts

Note: *Diagnostic casts are payable at 50% of United Concordia's allowance, once per orthodontic treatment plan, when provided with covered orthodontic procedures. Payment for diagnostic casts will be applied toward the annual maximum. For members in the OCONUS service area, there is no cost share for this service. For Selected Reserve and IRR family members and for IRR service members (other than Special Mobilization Category), the Government will not pay any cost shares or any difference between the dentist's billed charge and United Concordia's allowance.*

R=Report required

Code	Description of Service
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 (as part of contract)

D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8690 R	Orthodontic treatment (alternative billing to a contract fee)

Benefits and Limitations for Orthodontic Services

- Payment for diagnostic services performed in conjunction with orthodontics is applied to the member's annual maximum, except as identified in the note under the "Diagnostic Services" section.
- Orthodontic consultations will be processed as comprehensive or periodic evaluations and are subject to the same time limitations. See "Diagnostic Services" for more information.
- 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).
- Orthodontic treatment is available for spouses and Selected Reserve and IRR service members up to, but not including, 23 years of age.

***Note*: Selected Reserve and IRR members 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.*

- Initial payment for orthodontic services will not be made until a banding date has been submitted to United Concordia.
- All retention and case-finishing procedures are integral to the total case fee.
- Observations and adjustments are integral to the payment for retention appliances.
- Repair of damaged orthodontic appliances is not covered.
- 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.
- The replacement of a lost or missing appliance is not a covered benefit.
- Myofunctional therapy is integral to orthodontic treatment and is not payable as a separate benefit.
- 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.
- 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. United Concordia uses this code (D8670) when making periodic payments as part of the complete treatment plan payment.
- It is the dentist's and the member's responsibility to notify United Concordia if orthodontic treatment is discontinued or completed sooner than anticipated.

Note: *For more information, please refer to the "Orthodontics" section of this booklet.*

General Services

Member cost share percentages may vary depending on the sponsor's pay grade and location (CONUS or OCONUS). Refer to the "Cost Shares Summary Chart" for the applicable cost share amount for your specific situation.

To be eligible for coverage, the following services must be directly related to the covered services already listed.

Emergency Services

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

General Anesthesia
R=Report required

Code	Description of Service
D9220 R	Deep sedation/general anesthesia - first 30 minutes
D9221 R	Deep sedation/general anesthesia - each additional 15 minutes

Intravenous Sedation
R=Report required

Code	Description of Service
D9241 R	Intravenous conscious sedation/analgesia - first 30 minutes
D9242 R	Intravenous conscious sedation/analgesia - each additional 15 minutes

Consultations

Code	Description of Service
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)

Office Visits

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

Medications
R=Report required

Code	Description of Service
D9610 R	Therapeutic drug injection, by report

Post Surgical Services
R=Report required

Code	Description of Service
D9930 R	Treatment of complications (post-surgical) unusual circumstances, by report

Miscellaneous Services
R=Report required
X=X-ray required

Code	Description of Service
D9940 R	Occlusal guard, by report
D9941	Fabrication of athletic mouthguard
D9974 X	Internal bleaching - per tooth

Benefits and Limitations for General Services

• 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.

• 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.

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

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

• For palliative (emergency) treatment to be covered, it must involve a problem or symptom that occurred suddenly and unexpectedly, that requires immediate attention.

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

• In order for palliative (emergency) treatment to be covered, 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.

• Consultations are covered only when provided by a dentist other than the practitioner providing the treatment.

• Consultations reported for a non-covered benefit, such as temporomandibular joint dysfunction (TMD), are not covered.

• 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.

• Therapeutic drug injections 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.

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

• 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 12 consecutive month period.

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

• 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 United Concordia for payment.

• 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.

Alternative/Optional Methods of Treatment

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

In cases where alternative methods of treatment exist, payment will be allowed for the least costly, professionally accepted treatment. Some examples of alternative treatment situations are as follows:

• Payment is requested for a fixed partial denture(s) (bridges), but it is determined that a removable partial denture would satisfactorily replace the missing teeth.

• Payment is requested for a porcelain to metal crown, but it is determined that a three-surface restoration is an acceptable option.

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 member decide to proceed with the more expensive treatment, the member will be financially responsible for the difference between the dentist's fee for the more expensive treatment and the payment for the alternative service. For example, if payment was requested for a fixed bridge(s), and it was determined that a removable partial denture was a satisfactory alternative treatment, and the member chose to have the fixed bridge(s) provided, the member would be responsible to pay the difference between the dentist's charge for the fixed bridge(s) and the United Concordia payment for the removable partial denture.

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

Non-Covered Services

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

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

• 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, United Concordia 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.

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

• Those which are experimental or investigative in nature.

• 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.

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

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

• Those for which the member would have no obligation to pay in the absence of this or any similar coverage.

• 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.

• Those performed prior to the member's effective coverage date.

• Those incurred after the termination date of the member's coverage unless otherwise indicated.

• Those which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist. (Services determined to be unnecessary or which

do not meet accepted standards of dental practice are not billable to the patient by a participating dentist unless the dentist notifies the patient of his/her liability prior to treatment and the patient chooses to receive the treatment. Participating dentists should document such notification in their records.)

• Those not meeting accepted standards of dental practice.

• Those which are for unusual procedures and techniques.

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

• Those resulting from the patient's failure to comply with professionally prescribed treatment.

• Telephone consultations.

• Any charges for failure to keep a scheduled appointment

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

• Duplicate and temporary devices, appliances, and services.

• Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD).

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

• Implantology and related services.

• 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.

• Restorations which are placed for cosmetic purposes or due to attrition, erosion, or abrasion.

• Gold foil restorations.

• 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.

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

• Adjunctive dental benefits as defined by applicable federal regulations.

• 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.

• Nitrous oxide.

• Oral sedation.

Adjunctive Services

Adjunctive dental care is dental care that is:

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

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

• Essential to the control of the primary medical condition.

• Required in preparation for or as the result of dental trauma, which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).

The TDP does not cover services that are adjunctive dental care. These are medical services that may be covered under TRICARE/Medical even when provided by a general dentist or oral surgeon, such as the following diagnoses or conditions:

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

• 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.

• 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.

• Total or complete ankyloglossia.

• Intraoral abscesses which extend beyond the dental alveolus.

• Extraoral abscesses.

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

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

• Prosthetic replacement of either the maxilla or mandible due to reduction of body tissues associated with traumatic injury (such as a gun shot wound) in addition to services related to treating neoplasms or iatrogenic dental trauma.

Orthodontics

Eligibility

Orthodontic treatment is available for family members (non-spouse) up to, but not including, 21 years of age. Family members, who are enrolled full-time at an accredited college or university, are eligible up to, but not including, 23 years of age. Orthodontic treatment is also available for spouses and Selected Reserve and IRR service members up to, but not including, 23 years of age. (In all cases, coverage is effective until the end of the month in which the member reaches the applicable age limit.) Enrollment should be verified with United Concordia prior to receiving any care.

***Note*: Selected Reserve and IRR members 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.*

The member receiving orthodontic care must be enrolled in the TDP each month in order for monthly payments to be made. If the member disenrolls or loses TDP coverage during the course of the monthly payments, payments cannot be issued for those months with no coverage. If the member's TDP coverage is reinstated during the original schedule of monthly payments, payments will be made but only for those months (current and past) for which the member was enrolled. For example: If the original schedule of orthodontic payments was for 12 months - January to December - and the member's coverage was cancelled March 1, payments can only be made for January and February. No payment can be made for March. However, if the member's coverage was reinstated on September 1, payments can be made for September, October, November, and December.

Orthodontic Lifetime Maximum

The maximum lifetime benefit for orthodontic services under the TDP is $1,500 per member. (Payment for diagnostic services performed in conjunction with orthodontics is applied to the member's $1,200 annual maximum.) Each orthodontic payment is conditional depending on the member's actual remaining orthodontic maximum balance. If the member's lifetime maximum has been met before the payment schedule has been completed, further payments are discontinued.

Orthodontic Treatment in the CONUS Service Area

Orthodontic Cost Share (CONUS)

The orthodontic services listed as covered procedures are payable at 50 percent of the dentist's charge or United Concordia's allowance, whichever is lower, subject to a lifetime maximum payment per member of $1,500. The member is responsible for the 50 percent fixed cost share until the benefit is exhausted or the lifetime orthodontic maximum is reached. When the maximum is reached, the member is responsible for the remainder of the fee (either United Concordia's allowance for a participating dentist or the billed amount for a non-participating dentist).

Orthodontic Payments (CONUS)

Orthodontic progress payments are based on the length of treatment planned by the dentist up to the $1,500 lifetime maximum. A claim should be submitted immediately following the banding date - **not** at the end of the orthodontic treatment. The schedule of payments is determined as follows:

• At initial banding, a payment of 25 percent of the total amount payable under the program is issued.

• The remaining 75 percent of the payable amount is paid in monthly installments, based on the estimated length of treatment.

• If the length of treatment is six months or less, United Concordia's payment will be made in one lump sum. If the length of treatment is more than six months but United Concordia's liability is $500 or less, payment will be made in one lump sum. If the length of treatment is more than six months, progress payments will be issued on a monthly basis.
• The member must be enrolled in the TDP during each month that payment is made.

• The monthly payments are calculated and processed automatically.

Orthodontic Payment Examples (CONUS)

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

Payment Calculations for Eligible Treatment (CONUS)

Note: *The following examples are intended only to show how payments are calculated; actual fees, duration of treatment, and payments will vary.*

In this example, United Concordia's fee allowance is $3,200, and the length of treatment is 24 months. The orthodontic payment would be calculated as follows:

a) United Concordia fee allowance x United Concordia cost share percentage = United Concordia liability (not to exceed $1,500 lifetime maximum): $3,200 x 50% = $1,600.

b) Lower of United Concordia liability ($1,600) or orthodontic maximum ($1,500) = $1,500.

c) Initial banding: $1,500 x 25% = $375.

d) Remaining balance: $1,500 - $375 = $1,125.

e) Remaining balance divided by months: $1,125 ÷ 24 = $46.88. This is rounded down to United Concordia's payment of $46 per month for 23 months.

f) One final monthly United Concordia payment will be $67 to adjust for rounding.

g) Member payment equals member cost share of $1,600 ($3,200 x 50%) plus amount exceeding lifetime maximum ($100): $1,600 + $100 = $1,700.

Payment Calculations for "Treatment in Progress" (CONUS)

In this example, the member began orthodontic treatment six months prior to becoming eligible for benefits under the TDP. United Concordia's fee allowance is $3,200. The total estimated length of treatment is 24 months. The member had no previous orthodontic coverage.

a) Total number of months – number of months prior to coverage = number of remaining months: 24 – 6 = 18.

b) Percentage of months prior to coverage: 6 ÷ 24 = 25%.

c) Amount prior to coverage (United Concordia fee allowance x percentage of months prior to coverage): $3,200 x 25% = $800.

d) United Concordia fee allowance – amount prior to coverage x United Concordia cost share percentage = United Concordia's liability (not to exceed $1,500 lifetime maximum): ($3,200 - $800) x 50% = $1,200.

e) Lower of United Concordia liability ($1,200) or lifetime orthodontic maximum ($1,500) = $1,200.

f) No initial banding payment will be made since banding was performed when the member was ineligible.

g) Remaining balance divided by months: $1,200 ÷ 18 = $66.67. This is rounded down to United Concordia's payment of $66 per month for 17 months.

h) One final monthly United Concordia payment will be $78 to adjust for rounding.

i) Member cost share equals total fee allowance less amount prior to coverage less United Concordia payment: $3,200 - $800 - $1,200 = $1,200.

Note: *The member's cost share pertains solely to orthodontic services received while enrolled in the TDP. The member is responsible for services received prior to enrollment.*

Orthodontic Treatment in the OCONUS Service Area

Note: *As a custom of OCONUS communities, sponsors and family members may have to pay for covered services before services are rendered.*

All enrollees must contact their respective Overseas Dental Treatment Facility (ODTF) or Overseas Lead Agent (or designee) before seeking orthodontic care OCONUS. Completion of a Non-Availability and Referral Form is required, in both non-remote and remote locations, before United Concordia can process orthodontic claims from OCONUS dentists for payment. The name of the orthodontist who performed (or will perform, in the case of a predetermination) the orthodontic services must appear on the

OCONUS Provider Listing prepared by the ODTF or Overseas Lead Agent (or designee). One exception is Canada, where members may receive care from any orthodontist; however, a Non-Availability and Referral Form is still required prior to obtaining treatment.

Orthodontic Cost Share (OCONUS)

For orthodontic services, members will continue to be responsible to pay the dentist the 50 percent cost share. However, the Government will pay any difference between the remaining 50 percent and the $1,500 lifetime maximum in orthodontic benefits. The Government will also pay any difference between the orthodontist's charge and United Concordia's allowance.

Note: *Although coverage is available for Selected Reserve and IRR family members and IRR (other than Special Mobilization Category) members, all cost shares and excess charges are the responsibility of the member.*

Orthodontic Payments (OCONUS)

Payment for orthodontic treatment initiated in the OCONUS service area will be issued in one lump sum, subject to approval of the OCONUS orthodontist's treatment plan. United Concordia will pay 50 percent of the allowed amount up to the member's $1,500 lifetime maximum. After the $1,500 lifetime maximum has been reached and the Government has satisfied its portion of the payment, the member is responsible for any remaining liability.

Sponsors and family members contemplating orthodontic care in the OCONUS service area are cautioned that, because OCONUS dentists are paid in a lump sum amount, their $1,500 lifetime maximum may be fully exhausted when they return to the CONUS service area, regardless of whether or not the orthodontic care was completed OCONUS.

United Concordia will make payment for covered services to either the orthodontist or member depending on which party submitted the claim. If the member submits the claim but would like the payment to be issued directly to the orthodontist, he or she must sign the portion of the claim that assigns benefits to the orthodontist.

Orthodontic Payment Example (OCONUS)

In this example, the total fee charged is $5,000 and the United Concordia fee allowance is $4,000:

a) United Concordia fee allowance x United Concordia cost share percentage = United Concordia liability: $4,000 x 50% = $2,000.

b) Member cost share equals United Concordia fee allowance x member cost share percentage: $4,000 x 50% = $2,000.

c) Lower of United Concordia liability ($2,000) or orthodontic lifetime maximum ($1,500) = $1,500. This is United Concordia's payment amount.

d) Difference between United Concordia liability ($2,000) and orthodontic lifetime maximum ($1,500) = $500. This amount will be paid by the Government.

e) Difference between total fee ($5,000) and United Concordia fee allowance ($4,000) = $1,000. This amount will be paid by the Government.

f) In this example, the member pays $2,000, United Concordia pays $1,500, and the Government pays $1,500 ($500 + $1,000).

Note: *For Selected Reserve and IRR family members and IRR (other than Special Mobilization Category) members, all cost shares and excess charges are the responsibility of the member; the Government will not pay these costs.*

Transferring Orthodontists - CONUS to CONUS

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

Transferring Orthodontists - CONUS to OCONUS

Orthodontic care initiated in the CONUS service area may be continued OCONUS as long as the orthodontic lifetime maximum has not been met. All enrollees must obtain a Non-Availability and Referral Form from their respective ODTF or Overseas Lead Agent (or designee) before transferring to an OCONUS orthodontist. Additionally, all enrollees must receive care from an orthodontist listed on the OCONUS Provider Listing. Upon approval of the OCONUS orthodontist's treatment plan, a lump sum payment will be issued based on the member's remaining orthodontic maximum. The Government will not pay for the portion of the member's maximum that has already been paid by United Concordia nor will the Government pay for any costs once the maximum has been met.

Choosing a Dentist

CONUS Dentists

Participating Dentists

TDP members residing CONUS must receive dental care at civilian dental offices. You may visit any civilian dentist of your choice. However, receiving treatment from a United Concordia participating dentist can save money, time, and paperwork.

A United Concordia participating dentist has signed a contractual agreement to follow United Concordia's rules for providing care and accepting payments. When using a participating dentist, members will never have to pay more than the applicable cost share percentage for covered services, subject to stated limitations and maximums. Specifically, United Concordia participating dentists agree to:

- Accept United Concordia's allowance for covered services as payment in full. This means that members only have to pay the applicable cost share percentage; you do not have to pay any part of the dentist's charge that exceeds United Concordia's allowance. Balance billing by participating dentists is prohibited.
- Accept direct payment from United Concordia for covered services. This means that the benefit payment will be sent directly to the dentist and the member will receive a Dental Explanation of Benefits (DEOB) noting the payment amount and any cost share for which the member is responsible.
- Complete the claim form at no extra charge and submit it to United Concordia.
- Participate in United Concordia's quality assurance programs.
- Submit predetermination requests, as appropriate.
- Provide any information needed by United Concordia to make coverage and payment determinations.

A complete dentist directory containing names and addresses of participating dentists is available on our website: **www.ucci.com**. Our website also provides directions to the dentist's office as well as the estimated driving time and distance.

Should you need help in locating a participating dentist, contact your HBA/installation contact or United Concordia's Customer Service Department at **1-800-866-8499**.

The TDP contract requires that a United Concordia participating general dentist be located within 35 miles of your home and be able to arrange an appointment within 21 days of your call to the dental office. United Concordia is committed to ensuring this level of service for members. We actively seek dentists to add to our participating dentist list so that you will be able to receive dental care at a convenient location and time. If you are unable to obtain an appointment with a general dentist within 21 days of your call and within 35 miles of your home, please notify United Concordia's Customer Service Department.

DD Form 2813, DoD Active Duty/Reserve Forces Dental Examination

Health Affairs policy 01-025 directed the Services to ensure all members of the Selected Reserve undergo an annual dental examination. The DD Form 2813, DoD Active Duty/Reserve Forces Dental Examination, will be used to assist the Reserve components (RC) in documenting member dental health.

United Concordia participating dentists will complete the DD Form 2813 at no additional cost to the enrollee. The RC member is responsible for obtaining the examination, providing the form to the dentist, and reporting the result to his or her Service. The DD Form 2813 is available at the following web site: http://web1.whs.osd.mil/icdhome/forms.htm. RC members are encouraged to contact their Uniformed Service representative to determine their Service-specific requirements for this document before scheduling their annual dental examination.

Non-participating Dentists

Dentists who have not signed a contract with United Concordia are considered non-participating dentists. These dentists may bill members their full fee. This means the member will have to pay any difference between United Concordia's allowance and the amount charged by the non-participating dentist, in addition to the applicable cost share percentage. These dentists may submit claim forms for members or they may ask you to submit them.

Non-participating dentists may accept direct payment from United Concordia or may allow the benefit payment to be sent to the member. To send payment directly to a non-participating dentist, the member must sign an assignment of benefits statement on the claim form. This allows United Concordia to send payment to the non-participating dentist and to notify the member with a DEOB. If the assignment of benefits provision is not signed, United Concordia's

payment will be sent to the member and he/she will be responsible for paying the dentist.

Ask the dentist if he or she is a participating dentist with United Concordia. If so, you may continue to receive care from him or her and have all the advantages of using a participating dentist as listed above. If the dentist is non-participating, you may continue to receive care, but be aware that you will have to pay any difference between United Concordia's allowance and your dentist's full charge. If the dentist is interested in becoming a participating dentist, ask him or her to call United Concordia's Customer Service Department at **1-800-866-8499** or visit our website at **www.ucci.com**.

See the "General Policies" section for more information on the differences between participating and non-participating dentists.

OCONUS Dentists

United Concordia is not required to establish a network of dentists in the OCONUS service area. The Overseas Dental Treatment Facilities (ODTFs) and Overseas Lead Agents identify acceptable host nation dentists for possible referrals. The Government includes these host nation dentists in the OCONUS Provider Listing which is forwarded to United Concordia to assist in claims processing.

Restrictions for the location of a dentist within 35 miles of a member's home and the 21-day limit for obtaining an appointment are not applicable for members in OCONUS locations.

Non-remote Dentists

Active duty family members in OCONUS non-remote areas must utilize dentists whose names appear on the Overseas Lead Agent OCONUS Provider Listing for both non-orthodontic and orthodontic services in order to receive payment from United Concordia.

Selected Reserve and IRR members and their family members are required to use dentists on the OCONUS Provider Listing for orthodontic services only. Any dentist may be used for non-orthodontic services; however, dentists in the OCONUS Provider Listing are recommended.

Remote Dentists

When obtaining non-orthodontic care in remote OCONUS areas, all enrolled members may seek care from any dentist but are encouraged to utilize OCONUS Provider Listing that may be available through their respective Overseas Lead Agents, U.S. Embassy or Consulate office or from other local representatives of the U.S. Government. If the Overseas Lead Agent subsequently develops an OCONUS Provider Listing for specific remote locations, the member will be required to utilize dentists on these lists in order for claims for covered services to be processed for payment under the TDP.

For orthodontic care, all enrollees must use an orthodontist identified on the OCONUS Provider Listing. This listing is developed and maintained, where available, by Overseas Lead Agents (or designees). One exception is Canada, where members may receive care from any orthodontist; however, a Non-Availability and Referral Form is still required prior to obtaining treatment.

Claims (CONUS)

United Concordia will accept claims filed on any standard dental claim form of the American Dental Association or the TDP claim form developed by United Concordia. A separate claim form must be submitted for each member receiving services.

CONUS Claim Submission

Members in the CONUS service area may go to any authorized/licensed dentist of their choice. If the dentist is a participating dentist, his/her office will handle all paperwork, including filing claims.

If the dentist is not a United Concordia participating dentist, members may need to file their own claims. The TDP CONUS Claim Form is available on United Concordia's website, **www.ucci.com**.

Claim Filing Deadline

All claim forms should be submitted to United Concordia as soon as possible after the service, preferably within 60 days of the date of service. Claims submitted more than 12 months after the month in which the service was provided will be denied. Prompt submission is especially important for claims involving an orthodontic treatment plan because the banding date is used to determine timely filing.

CONUS Claim Payments

If a member visits a participating dentist, United Concordia will pay the dentist directly for covered services, less any cost share. It is up to the member and dentist to make arrangements for payment of the cost share amount.

When services are performed by a non-participating dentist, United Concordia will pay the member for eligible, covered services, up to United Concordia's allowance, less any cost share. Any part of the dentist's fee exceeding United Concordia's allowance is the member's responsibil-

ity. United Concordia will pay a non-participating dentist directly only if benefits have been assigned to him/her. Assignment may be accepted by the dentist on a claim-by-claim basis.

Claims (OCONUS)

The TDP OCONUS Claim Form includes instructions to assist members with its completion and can be obtained from our website, **www.ucci.com**. Claim forms are also available from Overseas Lead Agents, ODTFs, designated OCONUS Points of Contact (POCs), or by calling United Concordia's OCONUS Dental Unit.

OCONUS Claim Submission

Specific claims submission, processing, and payment procedures apply to OCONUS operations. Claims originating from the OCONUS service area should include the date(s) of service, the specific problem encountered, the specific tooth/teeth treated for each service performed, and the total charges. If a procedure code is not provided on the claim form, a complete description of the service performed, including applicable tooth/teeth numbers, should be provided. For United Concordia to process claims, the following information is needed:

- A completed claim form.
- A Dentist Bill or Statement of Charges. (If the specific service(s) provided are repeated on the claim form, a separate office bill is not needed.)
- A Non-Availability and Referral Form. (This form is required for orthodontic services for all enrollees. It is also required for non-orthodontic services for active duty family members in non-remote OCONUS locations.)

Note: *Members must use a dentist on the OCONUS Provider Listing for all services requiring a Non-Availability and Referral Form or the claim will be denied. One exception is Canada, where members may receive care from any orthodontist; however, a Non-Availability and Referral Form is still required prior to obtaining treatment.*

Whoever submits the claim to United Concordia must make sure all the appropriate information is provided. If the necessary information is not provided, claim payment will be denied.

Claim Filing Deadline

The TDP OCONUS Claim Form must be completed and submitted to United Concordia as soon as possible following the date of service, preferably within 60 days. However, if any claim is submitted to United Concordia more than 12 months after the month in which the service was completed, the claim will be denied for timeliness.

Bills submitted to United Concordia without a properly completed claim form will result in processing delays or denial of the claim. If additional information is required to process the claim, United Concordia may contact the dentist or member, as necessary.

OCONUS Claim Payments

As a custom of OCONUS communities, sponsors and family members may have to pay for covered services before services are rendered.

United Concordia will make payment for covered services to either the dentist or member depending on which party sent the claim. In cases where the dentist forwarded the claim, United Concordia will issue payment to the dentist and a DEOB to both the dentist and the member. In cases where the member forwarded the claim, United Concordia will issue payment and a DEOB to the member. If the member submits the claim and states that payment should be made directly to the dentist, the member must sign the portion of the claim form that assigns benefits to the dentist. If United Concordia is unable to determine which party forwarded the claim, payment will be issued to the dentist.

All claims submitted by dentists from the OCONUS service area will be paid in foreign currency to the dentists, subject to the availability of these currencies through recognized U.S. banking institutions. One exception is Turkey, where claims to dentists will be paid in U.S. dollars.

All claims submitted by enrollees will be paid in U.S. dollars unless the enrollee requests payment in local currency. If a member submits the claim and assigns payment directly to the dentist, the claim will be paid to the dentist in foreign currency. After a foreign draft (in foreign currency) has been issued, payment will not be changed to U.S. dollars. All payments requiring conversion to foreign currency will be calculated based on the exchange rate in effect on the last date of service listed on the claim or bill.

OCONUS Referral Procedures

To receive claim payment in the OCONUS service area, members may have to obtain a Non-Availability and Referral Form and visit specific dentists, depending on their location and type of dental service. Specific rules apply depending if treatment is received in a non-remote or remote area.

Referral Procedures - Non-remote Locations

In non-remote areas, active duty family members must receive a referral from an ODTF representative prior to receiving any (non-orthodontic and orthodontic) dental treatment. A Non-Availability and Referral Form must be submitted for claim payment. Once a referral has been obtained, the member must visit a dentist whose name appears on the OCONUS Provider Listing prepared by the Government. If the Non-Availability and Referral Form is not submitted, or if treatment is provided by a dentist not on the OCONUS Provider Listing, the claim will be denied.

Selected Reserve and IRR members and their family members are required to obtain Non-Availability and Referral Forms *for orthodontic care only,* and they must also use orthodontists on the OCONUS Provider Listing.

Referral Procedures - Remote Locations

In remote areas, all enrollees are required to obtain referrals for orthodontic treatment only. A representative of the Overseas Lead Agent office (or designee) must complete a Non-Availability and Referral Form for prescribed care to be performed by a dentist identified on the OCONUS Provider Listing before that care will be considered for payment by United Concordia. The Overseas Lead Agent (or designee) will complete and approve this form and forward it to United Concordia as authorization to receive orthodontic services from an OCONUS dentist. All members are required to use dentists identified on the OCONUS Provider Listing.

For non-orthodontic care, members do not need a referral. Additionally, members may seek care from any dentist but are encouraged to use the OCONUS Provider Listing that may be available through their respective Overseas Lead Agent, U.S. Embassy or Consulate office or from other local representatives of the U.S. Government.

If the Overseas Lead Agent subsequently develops an OCONUS Provider Listing for specific remote locations, the member will be required to utilize dentists on these lists in order for the claim to be considered for payment under the TDP.

Non-Availability and Referral Forms

Non-Availability and Referral Forms are valid for 120 calendar days from the date of issue by the ODTF or Overseas Lead Agent.

In instances where a Non-Availability and Referral Form is required, United Concordia will process and deny claim payment for any one or more of the following reasons:

- When the Non-Availability and Referral Form is not included with the claim.
- If the dentist is not listed on the most current OCONUS Provider Listing.
- If the date of service is outside the 120-calendar day time frame.
- If a properly completed claim form is not attached to the bill.
- If the referral is for a non-covered service.
- If the member is no longer enrolled in the TDP when the services are received.

When a claim is denied for these reasons, all appropriate parties will receive a DEOB informing them of the reason for the denial.

Non-Availability and Referral Forms are not blanket approvals for dental care from OCONUS dentists, except for continuing care for a specific dental treatment which requires multiple visits (e.g., orthodontics, crowns). If the Non-Availability and Referral Form addresses a continuing care situation that will exceed the 120-calendar day time frame, the original Non-Availability and Referral Form will be applied to the entire course of treatment. To receive payment, a copy of the form must be attached to each bill and claim form submitted over the course of the prescribed treatment.

In continuing care situations and where multiple claims are submitted, a copy of the form must accompany each claim submitted. In orthodontic cases where a lump sum payment is issued to the dentist, the form need only be submitted once.

Non-Availability and Referral Forms and Emergency Care

A Non-Availability and Referral Form is not required for United Concordia to process claims for emergency dental care in either non-remote or remote OCONUS locations. However, United Concordia may contact the sponsor, family member, or dentist, as necessary, regarding the basis of the emergency.

OCONUS Point of Contact (POC) Program

Sponsors and family members who have questions about the OCONUS dental program or need help submitting OCONUS claims should contact their Overseas Lead Agent or ODTF to see if there is a designated OCONUS Point of Contact (POC) near their installation. The POC, an active duty service member or civilian employee designated by the

Uniformed Services, can assist family members and sponsors in receiving timely reimbursement for dental claims.

The POC will review the claim to ensure that it contains all of the information needed for processing and can submit claims and monitor claim status by fax or e-mail. If a claim is submitted by the POC, he or she will receive the reimbursement and/or DEOB and will be responsible for distributing them to the member or dentist.

Dental Explanation of Benefits (DEOB)

A Dental Explanation of Benefits (DEOB) is a computer-generated statement that explains how a claim was processed. When a claim is processed, a DEOB is generated and mailed to the member explaining what services were covered and the amount of cost share, if any. If there is a cost share amount, the member must pay that amount to the dentist as well as any non-covered costs. Participating dentists will also receive a copy of the DEOB. Non-participating dentists will receive a DEOB if benefits were assigned and payment is being issued.

UNITED CONCORDIA
TRICARE Dental Program

DENTAL
EXPLANATION OF BENEFITS
KEEP FOR YOUR TAX RECORDS

UNITED CONCORDIA COMPANIES, INC.
TDP - CUSTOMER SERVICE
P.O. BOX 69410
HARRISBURG PA 17106-9410

Sponsor: MAJ JAMES DOE
SSN: 999999999
Page: 1 of 2

Beneficiary: JANE J DOE
JCN: 45999999999
Date: 03/20/03

Provider: JOHN SMITH DMD
(0000999997)

PROCEDURE DESCRIPTION PROCEDURE CODE (NUMBER OF SERVICES) *TOOTH DESCRIPTION*	SERVICE DATE(S)	PROVIDER'S CHARGE	ALLOWANCE	AMOUNT PAID	AMOUNT NOT PAID	REMARKS
PERIODIC EVALUATION (001) D0120	03/04/03	50.00	25.00	25.00	25.00	Q1030
	TOTALS	50.00	25.00	25.00	25.00	

Q1030 These services were performed by a United Concordia Participating Provider. This Provider has agreed to accept the TDP ALLOWANCE for this service, unless otherwise noted in the TDP benefit booklet.

Your payment is the amount in the AMOUNT PAID column. This payment is included in the enclosed check.

To take advantage of Participating Provider savings, you must pay any outstanding COST SHARE amount(s) directly to the Provider.

UNITED CONCORDIA
TRICARE Dental Program
PO Box 69411
Harrisburg, PA 17106-9411

HAVE A QUESTION?

PLEASE CALL TDP CUSTOMER SERVICE 1-800-866-8499, Business Hours: Sunday, 7pm EST to Friday, 6pm, EST, U.S.A.

Service for the Hearing Impaired via TDD Equipment is available at 1-800-881-1354.

JANE J DOE
123 ANY STREET
ANYTOWN PA 99999-9999

THIS IS NOT A BILL

DP000007

How to Read the DEOB

At the top of the DEOB page, the following will be indicated:

- **Sponsor's name**: The name of the Uniformed Service member.
- **Sponsor's Social Security Number**.
- **Page number**: The number of pages in the DEOB.
- **Patient's name**: The name of the member who received the services.
- **ICN**: Internal Control Number. This is the unique number United Concordia uses to identify the claim. You will need to reference this number if you contact us with questions about the DEOB.
- **Date**: The issue date of the DEOB.
- **Provider**: Name of the dentist who performed the service and his/her dentist number.

Below this information is a table that explains how your claim was processed. This includes the procedure code identifying the service performed ("D" + four-digit number) and the tooth number (if applicable) identified by an asterisk (*).

- **Service date(s)**: The date the member received treatment.
- **Provider's charge**: The amount charged by the dentist.
- **Allowance**: The amount United Concordia allows for the service.
- **Amount paid**: The amount United Concordia paid for the treatment after deductions, where applicable.
- **Amount not paid**: Amounts that have not been paid. This includes the difference between the dentist's charge and United Concordia's allowance, any cost share amounts, other insurance amounts, etc.
- **Remarks**: The code in this field matches the code in the explanation field at the bottom of the DEOB.

The messages on the bottom of the DEOB explain:

- Whether the dentist who performed the treatment was a TDP participating dentist or non-participating dentist.
- The amount paid by United Concordia.
- Appeal rights and the process for requesting a reconsideration, if applicable.

Note: DEOBs issued for treatment received in the OCONUS service area may include additional information not indicated on CONUS DEOBs (e.g., foreign exchange rate). Members should direct inquiries to the Point of Contact (POC) at their installation or to United Concordia's OCONUS Dental Unit.

Questions About DEOBs

For questions about DEOBs, contact United Concordia. Refer to the "Directory" section of this booklet for the appropriate address and telephone number for your area. Be sure to have the following information available when calling:

- Sponsor's name
- Sponsor's Social Security Number
- Patient's name
- Dentist's address and telephone number
- ICN of claim from the DEOB

Appeals System

If an enrollee or participating dentist disagrees with United Concordia's benefit decision, that decision can be appealed. United Concordia provides an appeals system that allows full opportunity for eligible parties to appeal benefit decisions. This means that the member (or the custodial parent or guardian if the member is under age 18) or the participating dentist can request an appeal by following the steps discussed below.

A sponsor, parent, or guardian cannot appeal a decision for a member 18 years of age or older; however, he or she may represent the member if the sponsor, parent or guardian is appointed in writing. A copy of United Concordia's "Appointment of Individual to Act as Representative for Appeal" form is available on our website: **www.ucci.com**. This form should be completed, signed, and sent to United Concordia's Customer Service Department along with the reconsideration request.

There are three levels to the appeals system; the first is reconsideration.

Level I: Reconsideration

How to Request a Reconsideration

The request must be in writing and include all rationale (reason for the request), supporting documentation, (x-rays, PCS orders, if applicable, progress notes), and a copy of the initial determination. In addition, the reconsideration

request must be postmarked or received by United Concordia within 90 calendar days of the issue date of the DEOB. (This issue date is located on the upper right corner of the DEOB.) Because the request for reconsideration must be filed within 90 days, the appeal request should not be delayed for the acquisition of supporting records if the records are not readily available. If supporting records will be submitted at a later date, the appeal letter should contain the expected date of submission.

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

What Happens During a Reconsideration

United Concordia's Customer Service Representatives will review all documentation submitted and conduct a thorough investigation. They may contact the family member or the dentist for additional information, and in some cases, refer the claim to United Concordia's Dental Advisors.

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

Reconsideration requests must be submitted in writing to:

CONUS
United Concordia
TDP Customer Service
P.O. Box 69410
Harrisburg, PA 17106-9410

OCONUS
United Concordia
TDP OCONUS Dental Unit
P.O. Box 69418
Harisburg, PA 17106-9418
U.S.A.

Level II: Formal Review

How to Request a Formal Review from TMA

Members may request a formal review from TMA if they disagree with United Concordia's reconsideration and if the amount remaining in dispute is $50 or more. The letter containing notification of our reconsideration decision will include a notice of the member's right to a formal review and instructions on how to request one.

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

Appeals and Hearings Division
TRICARE Management Activity
16401 East Centretech Parkway
Aurora, CO 80011-9066

Level III: Hearing

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

Appeals and Hearings Division
TRICARE Management Activity
16401 East Centretech Parkway
Aurora, CO 80011-9066

What Can and Cannot Be Appealed

To appeal a claim, there must be an amount in dispute. This means that there must be a charge or portion of a charge that United Concordia has decided is not payable and which the member is responsible for paying. The amount in dispute is calculated as the amount of money United Concordia would pay if the services involved had been determined to be payable. Adverse decisions on predetermination requests may also be appealed.

The following issues cannot be appealed:

- Disputes regarding a requirement of law or regulation.
- The amount United Concordia determines to be the allowable charge.
- Member eligibility.
- Dentists who have been excluded or suspended by a government agency or state or local licensing authority.
- Amounts exceeding the member's contract year or lifetime maximum.

Who Can Request an Appeal

Parties who can request an appeal:

- Participating dentists (Non-participating dentists must be appointed, in writing, by the member.)
- The member who received dental services.
- Sponsors, parents, or guardians of members who are under 18 years of age.
- An individual who has been appointed, in writing, by the member to act as the member's representative in the appeal.

Who Cannot Request an Appeal

Parties who cannot request an appeal:

- Dentists who are disqualified or excluded from being authorized dentists.
- Dentists who are not participating dentist.
- Members who have an interest in receiving care or who have received care from a particular dentist who has been excluded, suspended, or terminated as an authorized dentist.
- Sponsors, parents, or guardians of family members older than 18 years of age are not parties to the initial determination. However, they may represent the family member if they are appointed (in writing) by the family member.
- Third parties such as other insurance companies.

Predetermination Requests

United Concordia encourages the use of predeterminations to determine the extent of coverage for a proposed course of treatment. This allows both the dentist and the member to know if the proposed service(s) will be covered and the anticipated amount of payment by United Concordia prior to receiving treatment. United Concordia suggests predetermination of benefits for the following non-emergency types of treatment: onlays, single crowns, prosthodontics, periodontics, orthodontics, and oral surgery services.

To request a predetermination, the dentist or member must submit a dental claim form and indicate on the form that predetermination is being requested. A claim may contain both request for payment and predetermination lines. No dates of service should be reported for those procedures for which predetermination is being requested. Also, the appropriate box on the claim form may be checked to identify predetermination.

Once the predetermination is finalized, United Concordia will notify both the member and the dentist through a Dental Predetermination Notification and Request for Payment Form. A predetermination is not a guarantee of payment but indicates how much would be payable given the information available at the time the determination is processed.

When the predetermined service has been provided, return the Dental Predetermination Notification and Request for Payment Form to United Concordia, indicating the date the service(s) was provided. If multiple services have been predetermined, it is not necessary to have all services performed in order for the predetermination notification to be returned for processing.

TDP predeterminations are valid for six months from the date of finalization. The Dental Predetermination Notification and Request for Payment Form contains the date that the predetermination was approved. If the reported service is performed after the predetermination approval has expired, the service will have to be reviewed to determine if it is still eligible for payment.

Coordination of Benefits (COB)

The sponsor or the sponsor's spouse may have other dental insurance. In this case, United Concordia will coordinate benefits between the two dental plans. Coordination of benefits is applicable only to persons who are insured through another dental benefit plan in addition to the TDP.

If a member receives services that are covered under this program and another group dental plan, coverage and benefits are governed by Coordination of Benefits (COB) rules. These rules determine which plan is primary (meaning which plan pays benefits first) and which plan pays benefits second, after the primary plan has made its determination and payment.

The primary plan pays benefits without regard to the secondary plan. The secondary plan then pays for any covered services which have not been paid by the primary plan, taking into consideration all program provisions and limitations. For example: You get a tooth filled and the dentist's charge is $40. If the primary plan pays $32, the secondary plan will coordinate with the other insurance carrier and pay the remaining $8, as long as the procedure is allowable according to the secondary plan's program provisions and limitations.

Note: *If the dentist is participating with the primary insurance carrier, United Concordia will pay the portion that is the member's responsibility up to, but not to exceed, the primary carrier's allowance.*

Claims should always be filed with the primary plan first. After payment has been received from the primary plan, the claim can be filed with the secondary plan. When submitting a claim to United Concordia for coordination under the TDP as secondary coverage, a copy of the primary carrier's Explanation of Benefits (EOB) must be attached. If the primary carrier's payment information is handwritten or typed on the claim form, but a physical EOB is not attached, payment may be denied.

In the case of a spouse who has his or her own dental plan, the spouse's dental plan is considered primary and the TDP is secondary.

If the spouse or child's other plan is primarily a medical insurance plan but includes a dental benefit, the other plan is considered secondary. In this instance, the claims should be sent to United Concordia first.

In the case of a child who is covered under two dental plans, the primary plan is usually determined by the "birthday rule" which has been established by the National Association of Insurance Commissioners. The birthday rule determines the first plan to pay benefits based on which parent's birthday falls earlier in a calendar year. For example: If the mother's birthday is January 2 and the father's birthday is January 12, the mother's dental plan is considered primary and would pay benefits first. The year of the parent's birth is not relevant in determining which coverage is primary.

An exception to this birthday rule occurs if the other dental plan uses the "gender rule." The gender rule specifies that the male parent's dental plan is considered the primary plan. If the other dental coverage uses the gender rule in determining coordination of benefits, United Concordia will defer to the gender rule and consider the male parent's dental plan as the primary plan.

In situations where the parents are divorced or separated and there are two dental plans, United Concordia considers the insurance plan of the parent with custody to be the primary plan. If the parent with custody has remarried, the stepparent's plan will pay before the plan of the parent without custody. An exception to this rule occurs when there is a court decree specifying which parent is responsible for insurance coverage.

Privacy Act and United Concordia

The Privacy Act of 1974 was established to guard against an invasion of privacy of any record kept on an individual by a government agency. As a federal contractor, United Concordia is bound by contract and by law to adhere to the Privacy Act.

The Privacy Act places restrictions on the information that Customer Service Representatives can provide. Some of these restrictions are summarized below:

• Personal information can only be released to the member to whom the information pertains if that member is age 18 or older. Written authorization is required from the member before United Concordia can release information to others.

A member who wishes to authorize release of information to another party may complete United Concordia's "Authorization for Release of Insurance/Records Information" form which is available on our website: **www.ucci.com**. The form should be completed and signed by the member receiving the services and sent to United Concordia.

• Parents or legal guardians of children under age 18 can receive information on the minor child, provided that the relationship to the minor child can be established.

• Prior to requesting information, a legal guardian or custodial parent must establish proof of guardianship, in writing, with United Concordia. United Concordia's "Custodial Parent Release" form is available on our website: **www.ucci.com**.

The release of information to someone other than the member requires authorization from the person to whom the information pertains. This means a sponsor cannot receive information on his/her spouse or dependent, age 18 or older, unless United Concordia has written authorization on file from that member.

If a member, age 18 or older, chooses to release his/her information to another party, he or she should send a written statement to United Concordia's TDP Customer Service

Department. The statement must be signed and dated and include the member's name, authorized party's name, and the sponsor's Social Security Number. Authorization will remain in effect indefinitely, unless it is revoked by the requestor in writing.

Quality of Care

Continuous quality assurance review procedures are employed to ensure that members receive necessary quality care and that services are billed properly.

United Concordia only pays benefits for dental services that meet acceptable standards of dental practice. In rare cases, a dentist may be removed from our listing of participating dentists if United Concordia determines that he or she is not providing care within acceptable standards of dental practice.

Questions concerning the quality of care received should first be discussed with your dentist. Concerns can often be handled by asking your dentist questions about your dental treatment. If you still have concerns after talking to your dentist, you may write to United Concordia at:

United Concordia
TDP Quality of Care
P.O. Box 69406
Harrisburg, PA 17106-9406

Letters should include the sponsor's name and Social Security Number, the member's name and relationship to the sponsor, the name and address of the dentist, and an explanation of your concern. United Concordia's trained staff will investigate your concern, resolve it as appropriate, and notify you of the results.

The quality of foreign dentists is not controlled by the Government or United Concordia or any of its agents or representatives. The Government's control over foreign dentists is limited to their inclusion in or exclusion from the OCONUS Provider Listing. Sponsor/family members should forward any complaints or concerns about foreign dental service or quality of care to United Concordia at the address listed above. Grievances received by ODTFs or Overseas Lead Agents should be forwarded to United Concordia for action.

Fraud and Abuse

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

- Submitting claims for services not received by TDP members.
- Billing or submitting claims for costs of non-covered or non-chargeable services disguised as covered items.
- Duplicate billing for claims.
- Misrepresentation by the dentist of his or her credentials or concealing information or business practices that bear on the dentist's qualification for authorized TDP provider status.
- Performing unnecessary services for TDP enrollees.
- Improper billing practices by dentists.
- Waiver of member cost shares.

Members have an opportunity to detect fraud and abuse that may take place. The key is carefully reviewing all DEOBs. Make sure that the information on the DEOB matches the services received. For example:

- Verify the type and number of services provided.
- Verify the date the services were provided.
- Review the payment to the dentist to determine if he or she was paid for more services than actually received.

United Concordia, as a federal contractor, is forbidden to pay claims for services provided by those dentists under exclusions/sanctions imposed by the Department of Health and Human Services (DHHS) under the terms of the Social Security Act. In other cases, dentists can be excluded or suspended if the Director, TMA (or designee) determines this administrative remedy is in the best interest of the TDP. The Government will notify United Concordia monthly concerning dentists who are under exclusions/sanctions or who have been reinstated.

Services provided by those dentists under exclusions/sanctions will be denied. In these cases, a message on the DEOB will state that the dentist has been sanctioned and cannot bill the member or United Concordia.

Reporting Fraud and Abuse

Members who believe that a dentist received insurance money for filing a false claim, inflating a claim, or billing for services not rendered, should report this information to United Concordia's Special Investigations Unit (SIU). Several resources are available for members to contact the SIU:

• Visit United Concordia's website, **www.ucci.com**. Select the "Fraud" icon from the homepage and follow the links to the "Fraud Complaint Form."

• Submit written correspondence to:

United Concordia
Special Investigations Unit
P.O. Box 69406
Harrisburg, PA 17106-9406

• Call the toll free fraud hotline at **1-877-968-7455**. The SIU maintains a 24-hour confidential voice mailbox for reporting suspected incidents of fraud.

Website

United Concordia encourages members with Internet access to take advantage of the information and services available on our website: **www.ucci.com**. The site is free, easy to use and accessible 24 hours per day. It includes information about program changes, premiums, and survivor benefits, as well as the following services:

Find a Dentist: Members can search the National Fee-For-Service Network to find a participating dentist. Several methods are available for performing searches, including the ability to locate dentists according to their specialty, city and state, or zip code. Members can also check the name of a specific dentist to see if he or she is in the network.

My Dental Benefits: Members can gain access to this feature by registering with a user name and password. There is a ten-day waiting period during which United Concordia will mail a confirmation letter acknowledging the member's registration. Once completed, members can use this service to do the following:

• View a list of covered members

• Check the status of a claim

• Request or print a replacement identification card

• Review a history of dental services submitted for each member

Make Premium Payments On-Line: Members, who pay premiums by the direct bill method, have the option to view bills and authorize payments on-line. This is a secure site and therefore requires members to register (on-line) with a user name and password.

Report Fraud On-Line: Members have an opportunity to detect and report dental fraud. One method for notifying United Concordia of suspected incidents of fraud is the On-Line Fraud Complaint Form. The form prompts members to provide all information necessary to determine if the incident merits an investigation.

Printable Forms: The following forms can be downloaded and printed:

• TDP CONUS and OCONUS claim forms

• TDP Enrollment/Change Form

• Authorization for Release of Insurance Records/Information Form

• Appointment of Individual to Act as Appeal Representative Form

HIPAA Privacy Statement

EFFECTIVE APRIL 14, 2003, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Legal Duty

United Concordia is committed to protecting your privacy and is required by federal and state laws to maintain the privacy of your protected health information. "Protected health information" or "PHI" is any information that individually identifies you and relates to your past, present, or future physical or mental health or condition; the provision of health care to you; or payment for health care provided to you.

This notice describes our policies and practices for collecting, handling, and protecting our members' PHI. We are required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI.

Due to changing circumstances, it may become necessary to revise our privacy policies and practices and the terms of this notice at any time and as permitted by law. Before making a significant change in our privacy practices, we will revise this notice and inform all affected members, in writing, prior to the change.

Uses and Disclosures of PHI

In order to administer our dental benefit programs effectively, we collect, use, and disclose PHI for certain activities, including payment and health care operations. The following is a description of how we may use and/or disclose your PHI for these purposes:

• **Payment:** We may use and disclose your PHI to pay claims for services provided by your dentist.

• **Health Care Operations:** We may use and disclose your PHI to determine our premiums for your dental plan and to conduct quality assessment and improvement activities. Please refer to 45 C.F.R. 164.501 for a complete list of all activities that are included within the definitions of "payment" and "health care operations."

• **Business Associates:** We may disclose PHI to other covered entities, or "business associates," who assist us in administering our programs and delivering health services to our members. We may contract with individuals or entities to perform various functions on our behalf or to provide certain types of services such as utilization management or subrogation. To perform these functions, business associates may receive, create, maintain, use, or disclose PHI but only after we acquire their written agreement to appropriately safeguard your information.

• **Other Covered Entities**: We may use or disclose your PHI to assist health care providers in connection with *their* treatment or payment activities, or to assist other covered entities in connection with certain of *their* health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you.

Other Possible Uses and Disclosures of PHI

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

• **To Plan Administrators**: We may disclose your PHI to the TRICARE Management Activity to perform administrative functions.

• **Marketing**: We may use your PHI to contact you with information about dental-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities.

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

• **Public Health and Safety**: We may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health or safety or to the health or safety of others. We may disclose your PHI for the purpose of reporting abuse, neglect, domestic violence, or other crimes.

• **Required by Law**: We may use or disclose your PHI when we are required to do so by law. For example, we

may disclose your PHI when authorized by workers' compensation or similar programs which provide benefits for work-related injuries or illness.

• **Process and Proceedings:** We may disclose your PHI in response to a court order, subpoena, or other lawful process.

• **Law Enforcement:** We may disclose limited information to a law enforcement official concerning the PHI of a suspect, fugitive, material witness, crime victim, or missing person.

• **Military and National Security:** We may disclose the PHI of Armed Forces personnel to Military authorities under certain circumstances. We may disclose PHI to authorized federal officials for national security activities.

• **To You and on Your Authorization:** We must disclose your PHI to you, as described in the "Individual Rights" section of this notice (below). You may give us written permission to use your PHI or to disclose it to anyone for any purpose. You may change your mind at any time; however, your decision to revoke your prior authorization will not affect any use or disclosures made while it was in effect. Without your written permission, we may not use or disclose your PHI for any reason except those described in this notice.

Individual Rights

Right to Inspect and Copy: You have the right to inspect and copy PHI that may be used to make decisions about your care – this includes dental records. Your request must be in writing, and if you request a copy of the information, we may charge a fee for the associated costs. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to PHI, you may request a review of that decision. Another health care professional will review your request and the denial, and we will comply with the outcome of the review.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes other than treatment, payment, health care operations, and certain other activities. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your PHI, a description of the PHI we disclosed, and the reason for the disclosure. If you request this list more than once in a 12-month period, we may charge you a fee for responding to these additional requests.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. Your request must be in writing, and you must tell us what information you want to limit; how you want the information to be limited; and to whom you want the limits to apply. We are not required to agree to your request for further restrictions.

Confidential Communication: You have the right to request that we communicate with you about PHI in a certain way or at a certain location. For example, you can ask that we only contact you at home or only by mail. You must make your request in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests as long as it permits us to collect premiums and pay claims under your dental plan.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact the United Concordia Privacy Department at 4401 Deer Path Road, Harrisburg, PA 17110 or by calling our toll free telephone number: **1-866-215-2352**.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about use, access, or disclosure of your PHI, you may contact us using the information listed above. You may also submit a written complaint directly to the U.S. Department of Health and Human Services (DHHS). We will provide you with the address to file your complaint with the DHHS upon request.

We support your right to protect the privacy of your dental information and will not retaliate in any way should you choose to file a complaint with us or with the DHHS.

Directory

CONUS Directory

Claims

United Concordia
TDP Claims Processing
P.O. Box 69411
Harrisburg, PA 17106-9411

Customer Service

Telephone Inquiries:
1-800-866-8499 (toll free)
24 hours per day
Monday - Friday

Telephone Inquiries - Hearing Impaired:
1-800-891-1854 (toll free TDD)

Correspondence Inquiries:
United Concordia
TDP Customer Service
P.O. Box 69410
Harrisburg, PA 17106-9410

E-Mail:
conus@ucci.com

OCONUS Directory

Claims

United Concordia
TDP OCONUS Dental Unit
P.O. Box 69418
Harrisburg, PA 17106-9418

Customer Service

Telephone Inquiries:
1-888-418-0466 (toll free) Available in the following locations only:

Australia	Netherlands
Bahrain	Norway
Belgium	Panama
Bolivia	Portugal
Columbia	Saudi Arabia
Egypt	South Korea
Germany	Spain
Greece	Switzerland
Iceland	Turkey
Italy	United Kingdom
Japan	

1-717-975-5017 (not toll free). To be used in all countries not listed above.

Representatives are available to assist members in English, German, and Italian 24 hours per day, Monday - Friday.

Correspondence Inquiries:
United Concordia
TDP OCONUS Dental Unit
P.O. Box 69418
Harrisburg, PA 17106-9418

E-Mail:
oconus@ucci.com

Enrollment and Billing

Enrollment Applications

Enrollment Form and Initial Payment - Mail:
United Concordia/TDP
P.O. Box 827583
Philadelphia, PA 19182-7583

Enrollment Form and Initial Payment (Credit Card Only) - Fax:
1-888-734-1944

Recurring Payments

United Concordia/TDP
P.O. Box 827388
Philadelphia, PA 19182-7388

Customer Service

Telephone Inquiries:
1-888-622-2256

General Correspondence:
United Concordia
TDP Enrollment and Billing
P.O. Box 69426
Harrisburg, PA 17106-9426

E-Mail:
eabem@ucci.com

Quality of Care

United Concordia
TDP Quality of Care
P.O. Box 69406
Harrisburg, PA 17106-9406

Fraud and Abuse Issues

Correspondence:
United Concordia
Special Investigations Unit
P.O. Box 69406
Harrisburg, PA 17106-9406

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

Defense Manpower Data Center Support Office (DSO)

Telephone:
1-800-538-9552

Glossary

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

Adjudication
Claim processing procedures to determine benefits.

Allowance
The amount United Concordia calculates for each covered service to determine the amount we will pay. This includes the amount of the member's cost share, if any.

Appeals/Reconsiderations
Procedures provided for members and dentists who disagree with United Concordia's claim decisions.

Assignment of Benefits
Method by which payment for covered services is made to a non-participating dentist. If no assignment of benefits is made by the patient, payment will be made to the member for services provided by non-participating dentists.

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

Authorized Provider
Any provider who is fully licensed and approved to provide dental care or covered anesthesia benefits in the state where the provider is located. This includes dentists and Certified Registered Nurse Anesthetists (CRNAs). This also includes dental hygienists, practicing within the scope of their licensure, subject to any restrictions a state licensure or legislative body imposes regarding their status as independent providers of care.

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

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

Claim
Request for payment for services rendered.

Claim Form
Document that may be used either as a claim for payment or as a request for predetermination. If the date of service is left blank, the claim form is considered a predetermination request.

Contract Year
The 12-month period of time from February 1 to January 31 of the following year to which the annual $1,200 enrollee maximum applies.

CONUS Service Area
The area including the 50 United States, the District of Columbia, Guam, Puerto Rico, and the US Virgin Islands.

Coordination of Benefits
Rules that determine payment of claims when the member has other dental coverage in addition to the TDP.

Cost Share
The portion of the dentist's fee that the member is responsible for paying. This amount is indicated on the DEOB.

DEERS
Defense Enrollment Eligibility Reporting System. DEERS serves as a centarlized DoD data repository of personnel and health care benefits distributed to Uniformed Service members. DEERS is a functional component of the Defense Manpower Data Center.

Dentist
Licensed doctor (D.D.S. or D.M.D.) who is legally able to practice dentistry. Used in the TDP to also refer to certain Certified Dental Hygienists authorized by law to provide specified dental services.

DEOB
Dental Explanation of Benefits. Computer-generated notice mailed to members and dentists explaining benefits determinations, i.e., type of service received, the allowable charge, the amount billed, cost share amount, etc.

Dental Advisors
Dentists who work with United Concordia staff to review claims, predetermination requests, and appeals.

Dental Benefits Advisors (Regional Representatives)
United Concordia employees located across the country who conduct information meetings to educate members about their benefits with the TDP. They are in close contact with HBA/installation contacts and other points of contact at Uniformed Service installations.

Eligibility
The rules set forth by the Government to determine which members may be enrolled in the TDP.

Eligibility Date
The first of the month following enrollment and receipt of a dental premium. This date signifies when a member becomes eligible for the TDP.

Endodontic Services
Services relating to the treatment of diseases of the dental pulp, pulp chamber, and root canals.

Fixed Dental Treatment Facility (DTF)
Facilities which are staffed year-round and provide dental care to active duty and family members on a routine basis. Fixed DTFs are sometimes referred to as "full-time" DTFs.

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

In-Process Orthodontic Treatment
Orthodontic treatment that has already begun prior to the member's enrollment in the TDP.

Installation Contact
Personnel at Uniformed Service installations or units who are available to help members understand the TDP and TRICARE/Medical as well as the Uniformed Services' health care system.

Integral Services
Services which are performed in conjunction with another service which dentists would not normally itemize with a separate charge.

Leave and Earnings Statement (LES)
A Leave and Earnings Statement shows salary and deductions for a sponsor.

Maximums
Total dollar amount per member payable under the TDP. There is an annual maximum of $1,200 for all services with exception of orthodontic treatment, which has a lifetime maximum of $1,500.

Member
The member is the individual who is enrolled as a beneficiary of the TDP.

Non-Availability and Referral Form
Form used OCONUS by ODTFs and Overseas Lead Agents to refer enrolled members to local host country dentists.

Non-Participating Dentist
A dentist who has not signed a participating agreement with United Concordia.

Non-Remote OCONUS Service Area
This area consists of those OCONUS countries where the Uniformed Services have fixed dental treatment facilities.

OCONUS Service Area
Includes the continents of Asia, South America, Europe, Australia, Africa, Antarctica and the remaining countries outside the CONUS service area; it also includes all remaining island masses, and territorial waters not in the CONUS service area.

Other Dental Insurance
Additional coverage to TDP through an employer, association, or private insurer. See "Coordination of Benefits."

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

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

Other Than Special Mobilization Category (Individual Ready Reserve)
The majority of the individuals in the Individual Ready Reserve are in this category. Usually these members are trained and have previously served in the Active component or in the Selected Reserve. There are also some untrained individuals, personnel participating in officer training programs and personnel awaiting initial active duty.

Participating Dentist
An authorized dentist who has signed a participation agreement with United Concordia and who agrees to accept the United Concordia determined allowable charge as payment in full for covered services.

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

Permanent Change of Station (PCS)
For the purpose of establishing an exception to certain limitations of the TDP, PCS refers to a move from one

official duty station to another official duty station. For example, PCS does not include a relocation executed under separation or retirement orders to the home of record or place of selection.

Point of Contact (POC)
An active duty member or civilian employee located at OCONUS installations who assists family members/ sponsors with the submission of claims.

Predetermination
Written estimate provided by United Concordia in response to a request by a dentist or member for an estimate of coverage for future dental services.

Procedure Codes
Codes used to identify and define specific dental services.

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

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

Reconsideration
First level of the Appeals process. It enables members and dentists to seek a separate review from the initial payment determination to assess whether the initial payment decision was correct.

Remote OCONUS Service Area
This area consists of those OCONUS countries where the Uniformed Services do not have a fixed Dental Treatment Facility. This includes those countries that have "part-time" Uniformed Service Dental Treatment Facilities (DTFs) and no fixed DTFs.

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

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

Sponsors
Members of the Uniformed Services who enroll their family members in the TDP.

Student
Member under age 23 who is enrolled at an accredited college or university on a full-time basis and dependent on the service member for over 50 percent of his/her support.

TRICARE Dental Program (TDP)
Dental plan offered by the Department of Defense through TRICARE Management Activity and administered by United Concordia.

TRICARE Management Activity (TMA)
Formerly the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) and the TRICARE Support Office (TSO). This is the Government office responsible for oversight of the TDP contract.

Uniformed Services
The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the Public Health Service, and National Oceanic and Atmospheric Administration.

United Concordia
United Concordia Companies, Inc., a subsidiary of Highmark, Inc., located in Harrisburg, PA and the administrator of the TRICARE Dental Program.

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