

annual report to the Director, TRICARE Management Activity, or a designee, covering the 12 months of the previous calendar year. This report shall contain, as a minimum, the number and total dollar of cases of potential third-party payer/FMCRA liability referred to uniformed services claims authorities for further investigation and collection. These figures are to be itemized by the states and uniformed services to which the cases are referred.

(2) *Uniformed Services.* Each uniformed service will submit to the Director, TRICARE Management Activity, or designee, an annual report covering the 12 calendar months of the previous year, setting forth, as a minimum, the number and total dollar amount of cases involving TRICARE payments received from TRICARE contractors, the number and dollar amount of cases involving TRICARE payments received from other sources, and the number and dollar amount of claims actually asserted against, and the dollar amount of recoveries from, third-payment payers or under the FMCRA. The report, itemized by state and foreign claims jurisdictions, shall be provided no later than February 28 of each year.

(3) *Implementation of the reporting requirements.* The Director, TRICARE Management Activity, or a designee shall issue guidance for implementation of the reporting requirements prescribed by this section.

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#### § 199.13 TRICARE Dental Program.

(a) *General provisions—(1) Purpose.* This section prescribes guidelines and policies for the delivery and administration of the TRICARE Dental Program (TDP) of the Uniformed Services of the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, the Commissioned Corps of the U.S. Public Health Service (USPHS) and the National Oceanic and Atmospheric Administration (NOAA) Corps. The TDP is a premium based indemnity dental insurance coverage plan that is available to specified categories of individuals who are qualified for these benefits by virtue of their relationship to one of the seven (7) Uniformed Services

and their voluntary decision to accept enrollment in the plan and cost share (when applicable) with the Government in the premium cost of the benefits. The TDP is authorized by 10 U.S.C. 1076a, TRICARE dental program, and this section was previously titled the “Active Duty Dependents Dental Plan”. The TDP incorporates the former 10 U.S.C. 1076b, Selected Reserve dental insurance, and the section previously titled the “TRICARE Selected Reserve Dental Program”, § 199.21.

(2) *Applicability—(i) Geographic scope.* (A) The TDP is applicable geographically within the fifty (50) States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the U.S. Virgin Islands. These areas are collectively referred to as the “CONUS (or Continental United States) service area”.

(B) Extension of the TDP to areas outside the CONUS service area. In accordance with the authority cited in 10 U.S.C. 1076a(h), the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) may extend the TDP to areas other than those areas specified in paragraph (a)(2)(i)(A) of this section for the eligible members and eligible dependents of members of the Uniformed Services. These areas are collectively referred to as the “OCONUS (or outside the Continental United States) service area”. In extending the TDP outside the CONUS service area, the ASD(HA), or designee, is authorized to establish program elements, methods of administration and payment rates and procedures to providers that are different from those in effect for the CONUS service area to the extent the ASD(HA), or designee, determines necessary for the effective and efficient operation of the TDP. This includes provisions for preauthorization of care if the needed services are not available in a Uniformed Service overseas dental treatment facility and payment by the Department of certain cost-shares (or co-payments) and other portions of a provider’s billed charges for certain beneficiary categories. Other differences may occur based on limitations in the availability and capabilities of the Uniformed Service overseas dental treatment facility and a particular nation’s

civilian sector providers in certain areas. These differences include varying licensure and certification requirements of OCONUS providers, Uniformed Service provider selection criteria and local results of provider selection, referral, beneficiary pre-authorization and marketing procedures, and care for beneficiaries residing in distant areas. The Director, Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) shall issue guidance, as necessary, to implement the provisions of paragraph (a)(2)(i)(B). Beneficiaries will be eligible for the same TDP benefits in the OCONUS service area although services may not be available or accessible in all OCONUS countries.

(ii) *Agency.* The provisions of this section apply throughout the Department of Defense (DoD), the United States Coast Guard, the USPHS and NOAA.

(iii) *Exclusion of benefit services performed in military dental care facilities.* Except for emergency treatment, dental care provided outside the United States, services incidental to non-covered services, and services provided under paragraph (a)(2)(iv), dependents of active duty, Selected Reserve and Individual Ready Reserve members enrolled in the TDP may not obtain those services that are benefits of the TDP in military dental care facilities, as long as those covered benefits are available for cost-sharing under the TDP. Enrolled dependents of active duty, Selected Reserve and Individual Ready Reserve members may continue to obtain noncovered services from military dental care facilities subject to the provisions for space available care.

(iv) *Exception to the exclusion of services performed in military dental care facilities.*

(A) Dependents who are 12 years of age or younger and are covered by a dental plan established under this section may be treated by postgraduate dental residents in a dental treatment facility of the uniformed services under a graduate dental education program accredited by the American Dental Association if

(1) Treatment of pediatric dental patients is necessary in order to satisfy an accreditation standard of the Amer-

ican Dental Association that is applicable to such program, or training in pediatric dental care is necessary for the residents to be professionally qualified to provide dental care for dependent children accompanying members of the uniformed services outside the United States; and

(2) The number of pediatric patients at such facility is insufficient to support satisfaction of the accreditation or professional requirements in pediatric dental care that apply to such programs or students.

(B) The total number of dependents treated in all facilities of the uniformed services under paragraph (a)(2)(iv) in a fiscal year may not exceed 2,000.

(3) *Authority and responsibility—(i) Legislative authority—(A) Joint regulations.* 10 U.S.C. 1076a authorized the Secretary of Defense, in consultation with the Secretary of Health and Human Services, and the Secretary of Transportation, to prescribe regulations for the administration of the TDP.

(B) *Administration.* 10 U.S.C. 1073 authorizes the Secretary of Defense to administer the TDP for the Army, Navy, Air Force, and Marine Corps under DoD jurisdiction, the Secretary of Transportation to administer the TDP for the Coast Guard, when the Coast Guard is not operating as a service in the Navy, and the Secretary of Health and Human Services to administer the TDP for the Commissioned Corps of the USPHS and the NOAA Corps.

(ii) *Organizational delegations and assignments—(A) Assistant Secretary of Defense (Health Affairs) (ASD(HA)).* The Secretary of Defense, by 32 CFR part 367, delegated authority to the ASD(HA) to provide policy guidance, management control, and coordination as required for all DoD health and medical resources and functional areas including health benefit programs. Implementing authority is contained in 32 CFR part 367. For additional implementing authority see § 199.1. Any guidelines or policy necessary for implementation of this § 199.13 shall be issued by the Director, OCHAMPUS.

(B) *Evidence of eligibility.* DoD, through the Defense Enrollment Eligibility Reporting System (DEERS), is

responsible for establishing and maintaining a listing of persons eligible to receive benefits under the TDP.

(4) *Preemption of State and local laws.*

(i) Pursuant to 10 U.S.C. 1103 and section 8025 (fourth proviso) of the Department of Defense Appropriations Act, 1994, DoD has determined that, in the administration of 10 U.S.C. chapter 55, preemption of State and local laws relating to health insurance, prepaid health plans, or other health care delivery or financing methods is necessary to achieve important Federal interests, including, but not limited to, the assurance of uniform national health programs for Uniformed Service beneficiaries and the operation of such programs at the lowest possible cost to DoD, that have a direct and substantial effect on the conduct of military affairs and national security policy of the United States. This determination is applicable to the dental services contracts that implement this section.

(ii) Based on the determination set forth in paragraph (a)(4)(i) of this section, any State or local law relating to health or dental insurance, prepaid health or dental plans, or other health or dental care delivery or financing methods is preempted and does not apply in connection with the TDP contract. Any such law, or regulation pursuant to such law, is without any force or effect, and State or local governments have no legal authority to enforce them in relation to the TDP contract. (However, DoD may, by contract, establish legal obligations on the part of the dental plan contractor to conform with requirements similar or identical to requirements of State or local laws or regulations.)

(iii) The preemption of State and local laws set forth in paragraph (a)(4)(ii) of this section includes State and local laws imposing premium taxes on health or dental insurance carriers or underwriters or other plan managers, or similar taxes on such entities. Such laws are laws relating to health insurance, prepaid health plans, or other health care delivery or financing methods, within the meaning of the statutes identified in paragraph (a)(4)(i) of this section. Preemption, however, does not apply to taxes, fees, or other payments on net income or

profit realized by such entities in the conduct of business relating to DoD health services contracts, if those taxes, fees, or other payments are applicable to a broad range of business activity. For purposes of assessing the effect of Federal preemption of State and local taxes and fees in connection with DoD health and dental services contracts, interpretations shall be consistent with those applicable to the Federal Employees Health Benefits Program under 5 U.S.C. 8909(f).

(5) *Plan funds*—(i) *Funding sources.* The funds used by the TDP are appropriated funds furnished by the Congress through the annual appropriation acts for DoD, the Department of Health and Human Services and the Department of Transportation and funds collected by the Uniformed Services or contractor through payroll deductions or through direct billing as premium shares from beneficiaries.

(ii) *Disposition of funds.* TDP funds are paid by the Government (or in the case of direct billing, by the beneficiary) as premiums to an insurer, service, or prepaid dental care organization under a contract negotiated by the Director, OCHAMPUS, or a designee, under the provisions of the Federal Acquisition Regulation (FAR) (48 CFR chapter 1).

(iii) *Plan.* The Director, OCHAMPUS, or designee provides an insurance policy, service plan, or prepaid contract of benefits in accordance with those prescribed by law and regulation; as interpreted and adjudicated in accord with the policy, service plan, or contract and a dental benefits brochure; and as prescribed by requirements of the dental plan contractor's contract with the Government.

(iv) *Contracting out.* The method of delivery of the TDP is through a competitively procured contract. The Director, OCHAMPUS, or a designee, is responsible for negotiating, under provisions of the FAR, a contract for dental benefits insurance or prepayment that includes responsibility for:

(A) Development, publication, and enforcement of benefit policy, exclusions, and limitations in compliance with the law, regulation, and the contract provisions;

(B) Adjudicating and processing claims; and conducting related supporting activities, such as enrollment, disenrollment, collection of premiums, eligibility verification, provider relations, and beneficiary communications.

(6) *Role of Health Benefits Advisor (HBA).* The HBA is appointed (generally by the commander of an Uniformed Services medical treatment facility) to serve as an advisor to patients and staff in matters involving the TDP. The HBA may assist beneficiaries in applying for benefits, in the preparation of claims, and in their relations with OCHAMPUS and the dental plan contractor. However, the HBA is not responsible for the TDP's policies and procedures and has no authority to make benefit determinations or obligate the TDP's funds. Advice given to beneficiaries by HBAs as to determination of benefits or level of payment is not binding on OCHAMPUS or the dental plan contractor.

(7) *Right to information.* As a condition precedent to the provision of benefits hereunder, the Director, OCHAMPUS, or designee, shall be entitled to receive information from an authorized provider or other person, institution, or organization (including a local, State, or United States Government agency) providing services or supplies to the beneficiary for which claims for benefits are submitted. While establishing enrollment and eligibility, benefits, and benefit utilization and performance reporting information standards, the Government has established and does maintain a system of records for dental information under the TDP. By contract, the Government audits the adequacy and accuracy of the dental plan contractor's system of records and requires access to information and records to meet plan accountabilities, to assist in contractor surveillance and program integrity investigations and to audit OCONUS financial transactions where the Department has a financial stake. Such information and records may relate to attendance, testing, monitoring, examination, or diagnosis of dental disease or conditions; or treatment rendered; or services and supplies furnished to a beneficiary; and shall be necessary for the accurate and efficient administra-

tion and payment of benefits under this plan. To assist in claims adjudication, grievance and fraud investigations, and the appeals process, and before an interim or final determination can be made on a claim of benefits, a beneficiary or active duty, Selected Reserve or individual Ready Reserve member must provide particular additional information relevant to the requested determination, when necessary. Failure to provide the requested information may result in denial of the claim and inability to effectively investigate the grievance or fraud or process the appeal. The recipient of such information shall in every case hold such records confidential except when:

(i) Disclosure of such information is necessary to the determination by a provider or the dental plan contractor of beneficiary enrollment or eligibility for coverage of specific services;

(ii) Disclosure of such information is authorized specifically by the beneficiary;

(iii) Disclosure is necessary to permit authorized Government officials to investigate and prosecute criminal actions;

(iv) Disclosure constitutes a routine use of a routine use of a record which is compatible with the purpose for which it was collected. This includes a standard and acceptable business practice commonly used among dental insurers which is consistent with the principle of preserving confidentiality of personal information and detailed clinical data. For example, the release of utilization information for the purpose of determining eligibility for certain services, such as the number of dental prophylaxis procedures performed for a beneficiary, is authorized;

(v) Disclosure is pursuant to an order from a court of competent jurisdiction; or

(vi) Disclosure by the Director, OCHAMPUS, or designee, is for the purpose of determining the applicability of, and implementing the provisions of, other dental benefits coverage or entitlement.

(8) *Utilization review and quality assurance.* Claims submitted for benefits under the TDP are subject to review by the Director, OCHAMPUS, or designee,

for quality of care and appropriate utilization. The Director, OCHAMPUS, or designee, is responsible for appropriate utilization review and quality assurance standards, norms, and criteria consistent with the level of benefits.

(b) *Definitions.* For most definitions applicable to the provisions of this section, refer to Sec. 199.2. The following definitions apply only to this section:

(1) *Assignment of benefits.* Acceptance by a nonparticipating provider of payment directly from the insurer while reserving the right to charge the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member for any remaining amount of the fees for services which exceeds the prevailing fee allowance of the insurer.

(2) *Authorized provider.* A dentist, dental hygienist, or certified and licensed anesthetist specifically authorized to provide benefits under the TDP in paragraph (f) of this section.

(3) *Beneficiary.* A dependent of an active duty, Selected Reserve or Individual Ready Reserve member, or a member of the Selected Reserve or Individual Ready Reserve, who has been enrolled in the TDP, and has been determined to be eligible for benefits, as set forth in paragraph (c) of this section.

(4) *Beneficiary liability.* The legal obligation of a beneficiary, his or her estate, or responsible family member to pay for the costs of dental care or treatment received. Specifically, for the purposes of services and supplies covered by the TDP, beneficiary liability includes cost-sharing amounts or any amount above the prevailing fee determination by the insurer where the provider selected by the beneficiary is not a participating provider or a provider within an approved alternative delivery system. In cases where a nonparticipating provider does not accept assignment of benefits, beneficiaries may have to pay the nonparticipating provider in full at the time of treatment and seek reimbursement directly from the insurer for all or a portion of the nonparticipating provider's fee. Beneficiary liability also includes any expenses for services and supplies not covered by the TDP, less any available discount provided as a part of the in-

surer's agreement with an approved alternative delivery system.

(5) *By report.* Dental procedures which are authorized as benefits only in unusual circumstances requiring justification of exceptional conditions related to otherwise authorized procedures. These services are further defined in paragraph (e) of this section.

(6) *Contingency operation.* Defined in 10 U.S.C. 101(a)(13) as a military operation designated as a contingency operation by the Secretary of Defense or a military operation that results in the exercise of authorities for ordering Reserve Component members to active duty without their consent and is therefore automatically a contingency operation.

(7) *Cost-share.* The amount of money for which the beneficiary (or active duty, Selected Reserve or Individual Ready Reserve member) is responsible in connection with otherwise covered dental services (other than disallowed amounts) as set forth in paragraph (e) of this section. A cost-share may also be referred to as a "co-payment."

(8) *Defense Enrollment Eligibility Reporting System (DEERS).* The automated system that is composed of two (2) phases:

(i) Enrolling all active duty, Reserve and retired service members, their dependents, and the dependents of deceased service members; and

(ii) Verifying their eligibility for health care benefits in the direct care facilities and through the TDP.

(9) *Dental hygienist.* Practitioner in rendering complete oral prophylaxis services, applying medication, performing dental radiography, and providing dental education services with a certificate, associate degree, or bachelor's degree in the field, and licensed by an appropriate authority.

(10) *Dentist.* Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) who is licensed to practice dentistry by an appropriate authority.

(11) *Diagnostic services.* Category of dental services including:

(i) Clinical oral examinations;

(ii) Radiographic examinations; and

(iii) Diagnostic laboratory tests and examinations provided in connection

with other dental procedures authorized as benefits of the TDP and further defined in paragraph (e) of the section.

(12) *Endodontics*. The etiology, prevention, diagnosis, and treatment of diseases and injuries affecting the dental pulp, tooth root, and periapical tissue as further defined in paragraph (e) of this section.

(13) *Initial determination*. A formal written decision on a TDP claim, a request for TDP benefit pre-determination, a request by a provider for approval as an authorized provider, or a decision suspending, excluding or terminating a provider as an authorized provider under the TDP. Rejection of a claim or pre-determination, or of a request for benefit or provider authorization for failure to comply with administrative requirements, including failure to submit reasonably requested information, is not an initial determination. Responses to general or specific inquiries regarding TDP benefits are not initial determinations.

(14) *Nonparticipating provider*. A dentist or dental hygienist that furnished dental services to a TDP beneficiary, but who has not agreed to participate or to accept the insurer's fee allowances and applicable cost-share as the total charge for the services. A nonparticipating provider looks to the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member for final responsibility for payment of his or her charge, but may accept payment (assignment of benefits) directly from the insurer or assist the beneficiary in filing the claim for reimbursement by the dental plan contractor. Where the nonparticipating provider does not accept payment directly from the insurer, the insurer pays the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member, not the provider.

(15) *Oral and maxillofacial surgery*. Surgical procedures performed in the oral cavity as further defined in paragraph (e) of this section.

(16) *Orthodontics*. The supervision, guidance, and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and adjust-

ment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex as further defined in paragraph (e) of this section.

(17) *Participating provider*. A dentist or dental hygienist who has agreed to accept the insurer's reasonable fee allowances or other fee arrangements as the total charge (even though less than the actual billed amount), including provision for payment to the provider by the beneficiary (or active duty, Selected Reserve or Individual Ready Reserve member) or any cost-share for covered services.

(18) *Party to the initial determination*. Includes the TDP, a beneficiary of the TDP and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, provider who has been denied approval as an authorized TDP provider is a party to the initial determination, as is a provider who is suspended, excluded or terminated as an authorized provider, unless the provider is excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority.

(19) *Periodontics*. The examination, diagnosis, and treatment of diseases affecting the supporting structures of the teeth as further defined in paragraph (e) of this section.

(20) *Preventive services*. Traditional prophylaxis including scaling deposits from teeth, polishing teeth, and topical application of fluoride to teeth as further defined in paragraph (e) of this section.

(21) *Prosthodontics*. The diagnosis, planning, making, insertion, adjustment, refinement, and repair of artificial devices intended for the replacement of missing teeth and associated tissues as further defined in paragraph (e) of this section.

(22) *Provider*. A dentist, dental hygienist, or certified and licensed anesthetist as specified in paragraph (f) of this section. This term, when used in relation to OCONUS service area providers, may include other recognized professions authorized to furnish care under laws of that particular country.

(23) *Restorative services.* Restoration of teeth including those procedures commonly described as amalgam restorations, resin restorations, pin retention, and stainless steel crowns for primary teeth as further defined in paragraph (e) of this section.

(24) *Sealants.* A material designed for application on specified teeth to seal the surface irregularities to prevent ingress of oral fluids, food, and debris in order to prevent tooth decay.

(c) *Eligibility and enrollment*—(1) *General.* 10 U.S.C. 1076a, 1072(2)(A), (D), or (I), 1072(6), 10143 and 10144 set forth those persons who are eligible for voluntary enrollment in the TDP. A determination that a person is eligible for voluntary enrollment does not automatically entitle that person to benefit payments. The person must be enrolled in accordance with the provisions set forth in this section and meet any additional eligibility requirements in this part in order for dental benefits to be extended.

(2) *Eligibility*—(i) *Persons eligible.* Eligibility for the TDP is continuous in situations where the sponsor or member changes status between any of these eligible categories and there is no break in service or transfer to a non-eligible status.

(A) A person who bears one of the following relationships to an active duty member (under a call or order that does not specify a period of thirty (30) days or less) or a member of the Selected Reserve (as specified in 10 U.S.C. 10143) or Individual Ready Reserve (as specified in 10 U.S.C. 10144):

(1) *Spouse.* A lawful husband or wife, regardless of whether or not dependent upon the active duty, Selected Reserve or Individual Ready Reserve member.

(2) *Child.* To be eligible, the child must be unmarried and meet one of the requirements set forth in section 199.3(b)(2)(ii)(A)–(F) or 199.3(b)(2)(ii)(H).

(B) A member of the Selected Reserve of the Ready Reserve (as specified in 10 U.S.C. 10143).

(C) A member of the Individual Ready Reserve of the Ready Reserve (as specified in 10 U.S.C. 10144(b)) who is subject to being ordered to active duty involuntarily in accordance with 10 U.S.C. 12304.

(D) All other members of the Individual Ready Reserve of the Ready Reserve (as specified in 10 U.S.C. 10144(a)).

(ii) *Determination of eligibility status and evidence of eligibility*—(A) *Eligibility determination responsibility of the Uniformed Services.* Determination of a person's eligibility for the TDP is the responsibility of the member's Uniformed Service. For the purpose of program integrity, the appropriate Uniformed Service shall, upon request of the Director, OCHAMPUS, or designee, review the eligibility of a specified person when there is reason to question the eligibility status. In such cases, a report on the result of the review and any action taken will be submitted to the Director, OCHAMPUS, or designee.

(B) *Procedures for determination of eligibility.* Uniformed Service identification cards do not distinguish eligibility for the TDP. Procedures for the determination of eligibility are identified in § 199.3(f)(2), except that Uniformed Service identification cards do not provide evidence of eligibility for the TDP. Although OCHAMPUS and the dental plan contractor must make determinations concerning a member or dependent's eligibility in order to ensure proper enrollment and proper disbursement of appropriated funds, ultimate responsibility for resolving a member or dependent's eligibility rests with the Uniformed Services.

(C) *Evidence of eligibility required.* Eligibility and enrollment in the TDP will be verified through the DEERS. Eligibility and enrollment information established and maintained in the DEERS file is the only acceptable evidence of TDP eligibility and enrollment. It is the responsibility of the active duty, Selected Reserve or Individual Ready Reserve member or TDP beneficiary, parent, or legal representative, when appropriate, to provide adequate evidence for entry into the DEERS file to establish eligibility for the TDP, and to ensure that all changes in status that may affect eligibility are reported immediately to the appropriate Uniformed Service for action. Ineligibility for benefits is presumed in the absence of prescribed eligibility evidence in the DEERS file.

(3) *Enrollment*—(i) *Previous plans*—(A) *Basic Active Duty Dependents Dental*

*Benefit Plan.* The Basic Active Duty Dependents Dental Plan was effective from August 1, 1987, up to the date of implementation of the Expanded Active Duty Dependents Dental Benefit Plan. The Basic Active Duty Dependents Dental Benefit Plan terminated upon implementation of the expanded plan.

(B) *Expanded Active Duty Dependents Dental Benefit Plan.* The Expanded Active Duty Dependents Dental Benefit Plan (also known as the TRICARE Family Member Dental Plan) was effective from August 1, 1993, up to the date of implementation of the TDP. The Expanded Active Duty Dependents Dental Benefit Plan terminates upon implementation of the TDP.

(ii) *TRICARE Dental Program (TDP)*—

(A) *Election of coverage.* (1) Except as provided in paragraph (c)(3)(ii)(A)(2) of this section, active duty, Selected Reserve and Individual Ready Reserve service members may voluntarily elect to enroll their eligible dependents and members of the Selected Reserve and Individual Ready Reserve may voluntarily elect to enroll themselves following implementation of the TDP. In order to obtain TDP coverage, written or telephonic election by the active duty, Selected Reserve or Individual Ready Reserve member must be made and will be accomplished by submission or telephonic completion of an application to the dental plan contractor. This election can also be accomplished via electronic means.

(2) Eligible dependents of active duty members enrolled in the Expanded Active Duty Dependents Dental Benefit Plan at the time of implementation of the TDP will automatically be enrolled in the TDP. Eligible members of the Selected Reserve enrolled in the TRICARE Selected Reserve Dental Program at the time of implementation of the TDP will automatically be enrolled in the TDP. No election to enroll in the TDP will be required by the active duty or Selected Reserve member.

(B) *Premiums*—(1) Enrollment will be by either single or family premium as defined as follows:

(i) Single premium. One (1) covered eligible dependent or one (1) covered el-

igible Selected Reserve or Individual Ready Reserve member.

(ii) Family premium. Two (2) or more covered eligible dependents. Under the family premium, all eligible dependents of the active duty, Selected Reserve or Individual Ready Reserve member are enrolled.

(2) *Exceptions.* (i) An active duty, Selected Reserve or Individual Ready Reserve member may elect to enroll only those eligible dependents residing in one (1) location when the active duty, Selected Reserve or Individual Ready Reserve member has eligible dependents residing in two or more geographically separate locations (e.g., children living with a divorced spouse; a child attending college).

(ii) Instances where a dependent of an active duty member requires a hospital or special treatment environment (due to a medical, physical handicap, or mental condition) for dental care otherwise covered by the TDP, the dependent may be excluded from TDP enrollment and may continue to receive care from a military treatment facility.

(iii) A member of the Selected Reserve or Individual Ready Reserve may enroll separately from his or her eligible dependents. A member of the Selected Reserve or Individual Ready Reserve does not have to be enrolled in order for his or her eligible dependents to enroll under the TDP.

(C) *Enrollment period*—(1) *General.* Enrollment of eligible dependents or members is for a period of one (1) year followed by month-to-month enrollment as long as the active duty, Selected Reserve or Individual Ready Reserve member chooses to continue enrollment. Active duty members may enroll their eligible dependents and eligible members of the Selected Reserve or Individual Ready Reserve may enroll themselves or their eligible dependents in the TDP provided there is an intent to remain on active duty or as a member of the Selected Reserve or Individual Ready Reserve (or any combination thereof without a break in service or transfer to a non-eligible status) for a period of not less than one (1) year by the service member and their parent Uniformed Service. Beneficiaries enrolled in the TDP must remain enrolled for a minimum period of



one (1) year unless one of the conditions for disenrollment specified in paragraph (c)(3)(ii)(E) of this section is met.

(2) *Special enrollment period for Reserve component members ordered to active duty in support of contingency operations.* The mandatory twelve (12) month enrollment period does not apply to Reserve component members ordered to active duty (other than for training) in support of a contingency operation as designated by the Secretary of Defense. Affected Reserve component members may enroll in the TDP only if their orders specify that they are ordered to active duty in support of a contingency operation, as defined by 10 U.S.C., for a period of thirty-one (31) days or more. An affected Reserve component member must elect to enroll in the TDP and complete the enrollment application within thirty (30) days following entry on active duty or within sixty (60) days following implementation of the TDP. Following enrollment, beneficiaries must remain enrolled, with the member paying premiums, until the end of the member's active duty period in support of the contingency operation or twelve (12) months, whichever occurs first unless one of the conditions for disenrollment specified in paragraph (c)(3)(ii)(E) of this section is met.

(3) *Continuation of enrollment from Expanded Active Duty Dependents Dental Benefit Plan.* Beneficiaries enrolled in the Expanded Active Duty Dependents Dental Benefit Plan at the time when TDP coverage begins must complete their two (2) year enrollment period established under this former plan except if one of the conditions for disenrollment specified in paragraph (c)(3)(ii)(E) of this section is met. Once this original two (2) year enrollment period is met, the active duty member may continue TDP enrollment on a month-to-month basis. A new one (1) year enrollment period will only be incurred if the active duty member disenrolls and attempts to reenroll in the TDP at a later date.

(4) *Continuation of enrollment from TRICARE Selected Reserve Dental Program.* Beneficiaries enrolled in the TRICARE Selected Reserve Dental Program at the time when TDP coverage begins must complete their one

(1) year enrollment period established under this former program except if one of the conditions for disenrollment specified in paragraph (c)(3)(ii)(E) of this section is met. Once this original one (1) year enrollment period is met, the Selected Reserve member may continue TDP enrollment on a month-to-month basis. A new one (1) year enrollment period will only be incurred if the Selected Reserve member disenrolls and attempts to reenroll in the TDP at a later date.

(D) *Beginning dates of eligibility.* The beginning date of eligibility for TDP benefits is the first day of the month following the month in which the election of enrollment is completed, signed, and the enrollment and premium is received by the dental plan contractor, subject to a predetermined and publicized dental plan contractor monthly cut-off date, except that the date of eligibility shall not be earlier than the first day of the month in which the TDP is implemented. This includes any changes between single and family member premium coverage and coverage of newly eligible or enrolled dependents or members.

(E) *Changes in and termination of enrollment—(1) Changes in status of active duty, Selected Reserve or Individual Ready Reserve member.* When the active duty, Selected Reserve or Individual Ready Reserve member is separated, discharged, retired, transferred to the Standby or Retired Reserve, his or her enrolled dependents and/or the enrolled Selected Reserve or Individual Ready Reserve member loses eligibility and enrollment as of 11:59 p.m. on the last day of the month in which the change in status takes place. When the Selected Reserve or Individual Ready Reserve member is ordered to active duty for a period of more than 30 days without a break in service, the member loses eligibility and is disenrolled, if previously enrolled; however, their enrolled dependents maintain their eligibility and previous enrollment subject to eligibility, enrollment and disenrollment provisions described in this section and in the TDP contract.

(i) *Reserve component members separated from active duty in support of a contingency operation.* When a member

of a reserve component who is separated from active duty to which called or ordered in support of a contingency operation if the active duty is for more than 30 days, the member becomes eligible for Transitional Health Care pursuant to 10 U.S.C. 1145(a) and the member is entitled to dental care to which a member of the uniformed services on active duty for more than 30 days is entitled. Thus the member has no requirement for the TDP and is not eligible to purchase the TDP. Upon the termination of Transitional Health Care eligibility, the member regains TDP eligibility and is reenrolled, if previously enrolled.

(ii) *Dependents of members separated from active duty in support of a contingency operation.* Dependents of a member of a reserve component who is separated from active duty to which called or ordered in support of a contingency operation if the active duty is active for more than 30 days maintain their eligibility and previous enrollment, subject to eligibility, enrollment and disenrollment provisions described in this section and in the TDP contract. During the member's Transitional Health Care eligibility, the dependents are considered family members of Reserve Component members.

(iii) *Members separated from active duty and not covered by 10 U.S.C. 1145(a)(2)(B).* When the previously enrolled active duty member is transferred back to the Selected Reserve or Individual Ready Reserve, and is not covered by 10 U.S.C. 1145(a)(2)(B), without a break in service, the member regains TDP eligibility and is reenrolled; however, enrolled dependents maintain their eligibility and previous enrollment subject to eligibility, enrollment and disenrollment provisions described in this section and in the TDP contract.

(iv) Eligible dependents of an active duty, Selected Reserve or Individual Ready Reserve member serving a sentence of confinement in conjunction with a sentence of punitive discharge are still eligible for the TDP until such time as the active duty, Selected Reserve or Individual Ready Reserve member's discharge is executed.

(2) *Continuation of eligibility.* Eligible dependents of active duty members

who die while on active duty for a period of more than 30 days and eligible dependents of members of the Ready Reserve (*i.e.*, Selected Reserve or Individual Ready Reserve, as specified in 10 U.S.C. 10143 and 10144(b) respectively) who die, shall be eligible for continued enrollment in the TDP. This continued enrollment shall be up to (3) three years from the date of the member's death, except that, in the case of a dependent of the deceased who is described in 10 U.S.C. section 1072(2) by subparagraph (D) or (I), the period of continued enrollment shall be the longer of the following periods beginning on the date of the member's death:

(i) Three years.

(ii) The period ending on the date on which such dependent attains 21 years of age.

(iii) In the case of such dependent who, at 21 years of age, is enrolled in a full-time course of study in a secondary school or in a full-time course of study in an institution of higher education approved by the administering Secretary and was, at the time of the member's death, in fact dependent on the member for over one-half of such dependent's support, the period ending on the earlier of the following dates: The date on which such dependent ceases to pursue such a course of study, as determined by the administering Secretary; or the date on which such dependent attains 23 years of age.

(3) *Changes in status of dependent—(i) Divorce.* A spouse separated from an active duty, Selected Reserve or Individual Ready Reserve member by a final divorce decree loses all eligibility based on his or her former marital relationship as of 11:59 p.m. of the last day of the month in which the divorce becomes final. The eligibility of the active duty, Selected Reserve or Individual Ready Reserve member's own children (including adopted and eligible illegitimate children) is unaffected by the divorce. An unadopted stepchild, however, loses eligibility with the termination of the marriage, also as of 11:59 p.m. of the last day of the month in which the divorce becomes final.

(ii) *Annulment.* A spouse whose marriage to an active duty, Selected Reserve or Individual Ready Reserve member is dissolved by annulment loses eligibility as of 11:59 p.m. of the last day of the month in which the court grants the annulment order. The fact that the annulment legally declares the entire marriage void from its inception does not affect the termination date of eligibility. When there are children, the eligibility of the active duty, Selected Reserve or Individual Ready Reserve member's own children (including adopted and eligible illegitimate children) is unaffected by the annulment. An unadopted stepchild, however, loses eligibility with the annulment of the marriage, also as of 11:59 p.m. of the last day of the month in which the court grants the annulment order.

(iii) *Adoption.* A child of an active duty, Selected Reserve or Individual Ready Reserve member who is adopted by a person, other than a person whose dependents are eligible for TDP benefits while the active duty, Selected Reserve or Individual Ready Reserve member is living, thereby severing the legal relationship between the child and the active duty, Selected Reserve or Individual Ready Reserve member, loses eligibility as of 11:59 p.m. of the last day of the month in which the adoption becomes final.

(iv) *Marriage of child.* A child of an active duty, Selected Reserve or Individual Ready Reserve member who marries a person whose dependents are not eligible for the TDP, loses eligibility as of 11:59 p.m. on the last day of the month in which the marriage takes place. However, should the marriage be terminated by death, divorce, or annulment before the child is twenty-one (21) years old, the child again become eligible for enrollment as a dependent as of 12:00 a.m. of the first day of the month following the month in which the occurrence takes place that terminates the marriage and continues up to age twenty-one (21) if the child does not remarry before that time. If the marriage terminates after the child's 21st birthday, there is no reinstatement of eligibility.

(v) *Disabling illness or injury of child age 21 or 22 who has eligibility based on*

*his or her student status.* A child twenty-one (21) or twenty-two (22) years old who is pursuing a full-time course of higher education and who, either during the school year or between semesters, suffers a disabling illness or injury with resultant inability to resume attendance at the institution remains eligible for the TDP for six (6) months after the disability is removed or until the student passes his or her 23rd birthday, whichever occurs first. However, if recovery occurs before the 23rd birthday and there is resumption of a full-time course of higher education, the TDP can be continued until the 23rd birthday. The normal vacation periods during an established school year do not change the eligibility status of a dependent child twenty-one (21) or twenty-two (22) years old in full-time student status. Unless an incapacitating condition existed before, and at the time of, a dependent child's 21st birthday, a dependent child twenty-one (21) or twenty-two (22) years old in student status does not have eligibility related to mental or physical incapacity as described in § 199.3(b)(2)(iv)(C)(2).

(4) *Other—(i) Disenrollment because of no eligible beneficiaries.* When an active duty, Selected Reserve or Individual Ready Reserve member ceases to have any eligible beneficiaries, enrollment is terminated for those enrolled dependents.

(ii) *Option to disenroll as a result of a change in active duty station.* When an active duty member transfers with enrolled dependents to a duty station where space-available dental care for the enrolled dependents is readily available at the local Uniformed Service dental treatment facility, the active duty member may elect, within ninety (90) calendar days of the transfer, to disenroll their dependents from the TDP. If the active duty member is later transferred to a duty station where dental care for the dependents is not available in the local Uniformed Service dental treatment facility, the active duty member may reenroll their eligible dependents in the TDP provided the member, as of the date of reenrollment, otherwise meets the requirements for enrollment, including the intent to remain on active duty for a period of not less than one (1) year.

This disenrollment provision does not apply to enrolled dependents of members of the Selected Reserve or Individual Ready Reserve or to enrolled members of the Selected Reserve or Individual Ready Reserve.

(iii) *Option to disenroll due to transfer to OCONUS service area.* When an enrolled dependent of an active duty, Selected Reserve or Individual Ready Reserve member or an enrolled Selected Reserve or Individual Ready Reserve member relocates to locations within the OCONUS service area, the active duty, Selected Reserve or Individual Ready Reserve member may elect, within ninety (90) calendar days of the relocation, to disenroll their dependents from the TDP, or in the case of enrolled members of the Selected Reserve or Individual Ready Reserve, to disenroll themselves from the TDP. The active duty, Selected Reserve or Individual Ready Reserve member may reenroll their eligible dependents, or in the case of members of the Selected Reserve or Individual Ready Reserve, may reenroll themselves in the TDP provided the member, as of the date of reenrollment, otherwise meets the requirements for enrollment, including the intent to remain on active duty or as a member of the Selected Reserve or Individual Ready Reserve (or any combination thereof without a break in service or transfer to a non-eligible status) for a period of not less than one (1) year.

(iv) *Option to disenroll after an initial one (1) year enrollment.* When a dependent's enrollment under an active duty, Selected Reserve or Individual Ready Reserve member or a Selected Reserve or Individual Ready Reserve member's own enrollment has been in effect for a continuous period of one (1) year, the active duty, Selected Reserve or Individual Ready Reserve member may disenroll their dependents, or in the case of enrolled members of the Selected Reserve or Individual Ready Reserve may disenroll themselves at any time following procedures as set up by the dental plan contractor. Subsequent to the disenrollment, the active duty, Selected Reserve or Individual Ready Reserve member may reenroll their eligible dependents, or in the case of members of the Selected Reserve or In-

dividual Ready Reserve may reenroll themselves, for another minimum period of one (1) year. If, during any one (1) year enrollment period, the active duty, Selected Reserve or Individual Ready Reserve member disenrolls their dependents, or in the case of members of the Selected Reserve or Individual Ready Reserve disenrolls themselves, for reasons other than those listed in this paragraph (c)(3)(ii)(E) or fails to make premium payments, dependents enrolled under the active duty, Selected Reserve or Individual Ready Reserve member, or enrolled members of the Selected Reserve and Individual Ready Reserve, will be subject to a lock-out period of twelve (12) months. Following this period of time, active duty, Selected Reserve or Individual Ready Reserve members will be able to reenroll their eligible dependents, or members of the Selected Reserve or Individual Ready Reserve will be able to reenroll themselves, if they so choose. The twelve (12) month lock-out period applies to enrolled dependents of a Reserve component member who disenrolls for reasons other than those listed in this paragraph (c)(3)(ii)(E) or fails to make premium payments after the member has enrolled pursuant to paragraph (c)(3)(ii)(C) of this section.

(d) *Premium sharing*—(1) *General.* Active duty, Selected Reserve or Individual Ready Reserve members enrolling their eligible dependents, or members of the Selected Reserve or Individual Ready Reserve enrolling themselves, in the TDP shall be required to pay all or a portion of the premium cost depending on their status.

(i) *Members required to pay a portion of the premium cost.* This premium category includes active duty members (under a call or order to active duty that does not specify a period of thirty (30) days or less) on behalf of their enrolled dependents. It also includes members of the Selected Reserve (as specified in 10 U.S.C. 10143) and the Individual Ready Reserve (as specified in 10 U.S.C. 10144(b)) enrolled on their own behalf.

(ii) *Members required to pay the full premium cost.* This premium category includes members of the Selected Reserve (as specified in 10 U.S.C. 10143), and the Individual Ready Reserve (as

specified in 10 U.S.C. 10144), on behalf of their enrolled dependents. It also includes members of the Individual Ready Reserve (as specified in 10 U.S.C. 10144(a)) enrolled on their own behalf.

(2) *Proportion of premium share.* The proportion of premium share to be paid by the active duty, Selected Reserve and Individual Reserve member pursuant to paragraph (d)(1)(i) of this section is established by the ASD(HA), or designee, at not more than forty (40) percent of the total premium. The proportion of premium share to be paid by the Selected Reserve and Individual Reserve member pursuant to paragraph (d)(1)(ii) of this section is established by the ASD(HA), or designee, at one hundred (100) percent of the total premium.

(3) *Provision for increases in active duty, Selected Reserve and Individual Ready Reserve member's premium share.*

(i) Although previously capped at \$20 per month, the law has been amended to authorize the cap on active duty, Selected Reserve and Individual Ready Reserve member's premiums pursuant to paragraph (d)(1)(i) of this section to rise, effective as of January 1 of each year, by the percent equal to the lesser of:

(A) The percent by which the rates of basic pay of members of the Uniformed Services are increased on such date; or

(B) The sum of one-half percent and the percent computed under 5 U.S.C. 5303(a) for the increase in rates of basic pay for statutory pay systems for pay periods beginning on or after such date.

(ii) Under the legislation authorizing an increase in the monthly premium cap, the methodology for determining the active duty, Selected Reserve and Individual Ready Reserve member's TDP premium pursuant to paragraph (d)(1)(i) of this section will be applied as if the methodology had been in continuous use since December 31, 1993.

(4) *Reduction of premium share for enlisted members.* For enlisted members in pay grades E-1 through E-4, the ASD(HA) or designee, may reduce the monthly premium these active duty, Selected Reserve and Individual Ready Reserve members pay pursuant to paragraph (d)(1)(i) of this section.

(5) *Reduction of cost-shares for enlisted members.* For enlisted members in pay

grades E-1 through E-4, the ASD(HA) or designee, may reduce the cost-shares that active duty, Selected Reserve and Individual Ready Reserve members pay on behalf of their enrolled dependents and that members of the Selected Reserve and Individual Ready Reserve pay on their own behalf for selected benefits as specified in paragraph (e)(3)(i) of this section.

(6) *Premium payment method.* The active duty, Selected Reserve and Individual Ready Reserve member's premium share may be deducted from the active duty, Selected Reserve or Individual Ready Reserve member's basic pay or compensation paid under 37 U.S.C. 206, if sufficient pay is available. For members who are otherwise eligible for TDP benefits and who do not receive such pay and dependents who are otherwise eligible for TDP benefits and whose sponsors do not receive such pay, or if insufficient pay is available, the premium payment may be collected pursuant to procedures established by the Director, OCHAMPUS, or designee.

(7) *Annual notification of premium rates.* TDP premium rates will be determined as part of the competitive contracting process. Information on the premium rates will be widely distributed by the dental plan contractor and the Government.

(e) *Plan benefits—(1) General—(i) Scope of benefits.* The TDP provides coverage for diagnostic and preventive services, sealants, restorative services, endodontics, periodontics, prosthodontics, orthodontics and oral and maxillofacial surgery.

(ii) *Authority to act for the plan.* The authority to make benefit determinations and authorize plan payments under the TDP rests primarily with the insurance, service plan, or prepayment dental plan contractor, subject to compliance with Federal law and regulation and Government contract provisions. The Director, OCHAMPUS, or designee, provides required benefit policy decisions resulting from changes in Federal law and regulation and appeal decisions. No other persons or agents (such as dentists or Uniformed Services HBAs) have such authority.

(iii) *Dental benefits brochure*—(A) *Content*. The Director, OCHAMPUS, or designee, shall establish a comprehensive dental benefits brochure explaining the benefits of the plan in common lay terminology. The brochure shall include the limitations and exclusions and other benefit determination rules for administering the benefits in accordance with the law and this part. The brochure shall include the rules for adjudication and payment of claims, appealable issues, and appeal procedures in sufficient detail to serve as a common basis for interpretation and understanding of the rules by providers, beneficiaries, claims examiners, correspondence specialists, employees and representatives of other Government bodies, HBAs, and other interested parties. Any conflict, which may occur between the dental benefits brochure and law or regulation, shall be resolved in favor of law and regulation.

(B) *Distribution*. The dental benefits brochure will be available through the dental plan contractor and will be distributed with the assistance of the Uniformed Services HBAs and major personnel centers at Uniformed Service installations and headquarters to all members enrolling themselves or their eligible dependents.

(iv) *Alternative course of treatment policy*. The Director, OCHAMPUS, or designee, may establish, in accordance with generally accepted dental benefit practices, an alternative course of treatment policy which provides reimbursement in instances where the dentist and beneficiary select a more expensive service, procedure, or course of treatment than is customarily provided. The alternative course of treatment policy must meet following conditions:

(A) The service, procedure, or course of treatment must be consistent with sound professional standards of dental practice for the dental condition concerned.

(B) The service, procedure, or course of treatment must be a generally accepted alternative for a service or procedure covered by the TDP for the dental condition.

(C) Payment for the alternative service or procedure may not exceed the lower of the prevailing limits for the

alternative procedure, the prevailing limits or dental plan contractor's scheduled allowance for the otherwise authorized benefit procedure for which the alternative is substituted, or the actual charge for the alternative procedure.

(2) *Benefits*. The following benefits are defined (subject to the TDP's exclusions, limitations, and benefit determination rules approved by OCHAMPUS) using the American Dental Association's Council on Dental Care Program's Code on Dental Procedures and Nomenclature. The Director, OCHAMPUS, or designee, may modify these services, to the extent determined appropriate based on developments in common dental care practices and standard dental insurance programs.

(i) *Diagnostic and preventive services*. Benefits may be extended for those dental services described as oral examination, diagnostic, and preventive services defined as traditional prophylaxis (i.e., scaling deposits from teeth, polishing teeth, and topical application of fluoride to teeth) when performed directly by dentists and dental hygienists as authorized under paragraph (f) of this section. These include the following categories of service:

(A) Diagnostic services. (1) Clinical oral examinations.

(2) Radiographs and diagnostic imaging.

(3) Tests and laboratory examinations.

(B) Preventive services. (1) Dental prophylaxis.

(2) Topical fluoride treatment (office procedure).

(3) Other preventive services.

(4) Space maintenance (passive appliances).

(ii) *General services and services "by report"*. The following categories of services are authorized when performed directly by dentists or dental hygienists, as authorized under paragraph (f) of this section, only in unusual circumstances requiring justification of exceptional conditions directly related to otherwise authorized procedures. Use of the procedures may not result in the fragmentation of services normally included in a single procedure. The dental plan contractor may recognize a

“by report” condition by providing additional allowance to the primary covered procedure instead of recognizing or permitting a distinct billing for the “by report” service. These include the following categories of general services:

- (A) Unclassified treatment.
- (B) Anesthesia.
- (C) Professional consultation.
- (D) Professional visits.
- (E) Drugs.
- (F) Miscellaneous services.

(iii) *Restorative services*. Benefits may be extended for restorative services when performed directly by dentists or dental hygienists, or under orders and supervision by dentists, as authorized under paragraph (f) of this section. These include the following categories of restorative services:

- (A) Amalgam restorations.
- (B) Resin restorations.
- (C) Inlay and onlay restorations.
- (D) Crowns.
- (E) Other restorative services.

(iv) *Endodontic services*. Benefits may be extended for those dental services involved in treatment of diseases and injuries affecting the dental pulp, tooth root, and periapical tissue when performed directly by dentists as authorized under paragraph (f) of this section. These include the following categories of endodontic services:

- (A) Pulp capping.
- (B) Pulpotomy and pulpectomy.
- (C) Endodontic therapy.
- (D) Apexification and recalcification procedures.
- (E) Apicoectomy and periradicular services.
- (F) Other endodontic procedures.

(v) *Periodontic services*. Benefits may be extended for those dental services involved in prevention and treatment of diseases affecting the supporting structures of the teeth to include periodontal prophylaxis, gingivectomy or gingivoplasty, gingival curettage, etc., when performed directly by dentists as authorized under paragraph (f) of this section. These include the following categories of periodontic services:

- (A) Surgical services.
- (B) Periodontal services.
- (C) Other periodontal services.

(vi) *Prosthodontic services*. Benefits may be extended for those dental serv-

ices involved in fabrication, insertion adjustment, relinement, and repair of artificial teeth and associated tissues to include removable complete and partial dentures, fixed crowns and bridges when performed directly by dentists as authorized under paragraph (f)(4) of this section. These include the following categories of prosthodontic services:

- (A) Prosthodontics (removable).
  - (1) Complete and partial dentures.
  - (2) Adjustments to dentures.
  - (3) Repairs to complete and partial dentures.
  - (4) Denture rebase procedures.
  - (5) Denture reline procedures.
  - (6) Other removable prosthetic services.
- (B) Prosthodontics (fixed).
  - (1) Fixed partial denture pontics.
  - (2) Fixed partial denture retainers.
  - (3) Other partial denture services.

(vii) *Orthodontic services*. Benefits may be extended for the supervision, guidance, and correction of growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations through the use of orthodontic procedures and devices when performed directly by dentists as authorized under paragraph (f) of this section to include in-process orthodontics. These include the following categories of orthodontic services:

- (A) Limited orthodontic treatment.
- (B) Minor treatment to control harmful habits.
- (C) Interceptive orthodontic treatment.
- (D) Comprehensive orthodontic treatment.
- (E) Other orthodontic services.

(viii) *Oral and maxillofacial surgery services*. Benefits may be extended for basic surgical procedure of the extraction, reimplantation, stabilization and repositioning of teeth, alveoloplasties, incision and drainage of abscesses, suturing of wounds, biopsies, etc., when performed directly by dentists as authorized under paragraph (f) of this section. These include the following categories of oral and maxillofacial surgery services:

- (A) Extractions.
- (B) Surgical extractions.

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(C) Other surgical procedures.  
 (D) Alveoloplasty—surgical preparation of ridge for denture.  
 (E) Surgical incision.  
 (F) Repair of traumatic wounds.  
 (G) Complicated suturing.  
 (H) Other repair procedures.  
 (ix) Exclusion of adjunctive dental care. Adjunctive dental care benefits are excluded under the TDP. For further information on adjunctive dental care benefits under TRICARE/CHAMPUS, see § 199.4(e)(10).

(x) *Benefit limitations and exclusions.* The Director, OCHAMPUS, or designee, may establish such exclusions and limitations as are consistent with those established by dental insurance and prepayment plans to control utilization and quality of care for the services and items covered by the TDP.

(xi) *Limitation on reduction of benefits.* If a reduction in benefits is planned, the Secretary of Defense, or designee, may not reduce TDP benefits without notifying the appropriate Congressional committees. If a reduction is approved, the Secretary of Defense, or designee, must wait one (1) year from the date of notice before a benefit reduction can be implemented.

(3) *Cost-shares, liability and maximum coverage*—(i) *Cost-shares.* The following table lists maximum active duty, Selected Reserve and Individual Ready Reserve member and dependent cost-shares for covered services for participating and nonparticipating providers of care (see paragraph (f)(6) of this section for additional active duty, Selected Reserve and Individual Ready Reserve costs). These are percentages of the dental plan contractor's determined allowable amount that the active duty, Selected Reserve and Individual Ready Reserve member or beneficiary must pay to these providers. For care received in the OCONUS service area, the ASD(HA), or designee, may pay certain cost-shares and other portions of a provider's billed charge for enrolled dependents of active duty members (under a call or order that does not specify a period of thirty (30) days or less), and for members of the Selected Reserve (as specified in 10 U.S.C. 10143) and Individual Ready Reserve (as specified in 10 U.S.C. 10144(b)) enrolled on their own behalf.

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[In percent]

Covered services	Cost-share for pay grades E-1, E-2, E-3 and E-4	Cost-share for all other pay grades
Diagnostic .....	0	0
Preventive, except Sealants .....	0	0
Emergency Services .....	0	0
Sealants .....	20	20
Professional Consultations .....	20	20
Professional Visits .....	20	20
Post Surgical Services .....	20	20
Basic Restorative (example: amalgams, resins, stainless steel crowns) .....	20	20
Endodontic .....	30	40
Periodontic .....	30	40
Oral and Maxillofacial Surgery ..	30	40
General Anesthesia .....	40	40
Intravenous Sedation .....	50	50
Other Restorative (example: crowns, onlays, casts) .....	50	50
Prosthodontics .....	50	50
Medications .....	50	50
Orthodontic .....	50	50
Miscellaneous .....	50	50

(ii) *Dental plan contractor liability.* When more than twenty-five (25) percent or more than two hundred (200) enrollees in a specific five (5) digit zip code area are unable to obtain a periodic or initial (non-emergency) dentistry appointment with a network provider within twenty-one (21) calendar days and within thirty-five (35) miles of the enrollee's place of residence, then the TRICARE Management Activity (TMA) will designate that area as "non-compliant with the access standard." Once so designated, the dental program contractor will reimburse the beneficiary, or active duty, Selected Reserve or Individual Ready Reserve member, or the nonparticipating provider selected by enrollees in that area (or a subset of the area or nearby zip codes in other five (5) digit zip code areas as determined by TMA) at the level of the provider's usual fees less the applicable enrollee cost-share, if any. TMA shall determine when such area becomes compliant with the access standards. This access standard and associated liability does not apply to care received in the OCONUS service area.

(iii) *Maximum coverage amounts.* Beneficiaries are subject to an annual maximum coverage amount for non-orthodontic dental benefits and a lifetime maximum coverage amount for



orthodontics as established by the ASD (HA) or designee.

(f) *Authorized providers*—(1) *General*. Beneficiaries may seek covered services from 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 licensed 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.

(2) *Authorized provider status does not guarantee payment of benefits*. The fact that a provider is “authorized” is not to be construed to mean that the TDP will automatically pay a claim for services or supplies provided by such a provider. The Director, OCHAMPUS, or designee, also must determine if the patient is an eligible beneficiary, whether the services or supplies billed are authorized and medically necessary, and whether any of the authorized exclusions of otherwise qualified providers presented in this section apply.

(3) *Utilization review and quality assurance*. Services and supplies furnished by providers of care shall be subject to utilization review and quality assurance standards, norms, and criteria established under the TDP. Utilization review and quality assurance assessments shall be performed under the TDP consistent with the nature and level of benefits of the plan, and shall include analysis of the data and findings by the dental plan contractor from other dental accounts.

(4) *Provider required*. In order to be considered benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of a TDP authorized provider practicing within the scope of his or her license.

(5) *Participating provider*. An authorized provider may elect to participate for all TDP beneficiaries and accept the fee or charge determinations as established and made known to the provider by the dental plan contractor. The fee or charge determinations are binding upon the provider in accordance with the dental plan contractor's procedures for participation. The au-

thorized provider may not participate on a claim-by-claim basis. The participating provider must agree to accept, within one (1) day of a request for appointment, beneficiaries in need of emergency palliative treatment. Payment to the participating provider is based on the lower of the actual charge or the dental plan contractor's determination of the allowable charge; however, payments to participating providers shall be in accordance with the methodology specified in paragraph (g)(2)(ii) of this section. Payment is made directly to the participating provider, and the participating provider may only charge the beneficiary the percent cost-share of the dental plan contractor's allowable charge for those benefit categories as specified in paragraph (e) of this section, in addition to the full charges for any services not authorized as benefits.

(6) *Nonparticipating provider*. An authorized provider may elect to not participate for all TDP beneficiaries and request the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member to pay any amount of the provider's billed charge in excess of the dental plan contractor's determination of allowable charges (to include the appropriate cost-share). Neither the Government nor the dental plan contractor shall have any responsibility for any amounts over the allowable charges as determined by the dental plan contractor, except where the dental plan contractor is unable to identify a participating provider of care within thirty-five (35) miles of the beneficiary's place of residence with appointment availability within twenty-one (21) calendar days. In such instances of the nonavailability of a participating provider and in accordance with the provisions of the dental contract, the nonparticipating provider located within thirty-five (35) miles of the beneficiary's place of residence shall be paid his or her usual fees (either by the beneficiary or the dental plan contractor if the beneficiary elected assignment of benefits), less the percent cost-share as specified in paragraph (e)(3)(i) of this section.

(i) *Assignment of benefits*. A nonparticipating provider may accept assignment of benefits for claims (for

beneficiaries certifying their willingness to make such assignment of benefits) by filing the claims completed with the assistance of the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member for direct payment by the dental plan contractor to the provider.

(ii) *No assignment of benefits.* A nonparticipating provider for all beneficiaries may request that the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member file the claim directly with the dental plan contractor, making arrangements with the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member for direct payment by the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member.

(7) *Alternative delivery system*—(i) *General.* Alternative delivery systems may be established by the Director, OCHAMPUS, or designee, as authorized providers. Only dentists, dental hygienists and licensed anesthetists shall be authorized to provide or direct the provision of authorized services and supplies in an approved alternative delivery system.

(ii) *Defined.* An alternative delivery system may be any approved arrangement for a preferred provider organization, capitation plan, dental health maintenance or clinic organization, or other contracted arrangement which is approved by OCHAMPUS in accordance with requirements and guidelines.

(iii) *Elective or exclusive arrangement.* Alternative delivery systems may be established by contract or other arrangement on either an elective or exclusive basis for beneficiary selection of participating and authorized providers in accordance with contractual requirements and guidelines.

(iv) *Provider election of participation.* Otherwise authorized providers must be provided with the opportunity of applying for participation in an alternative delivery system and of achieving participation status based on reasonable criteria for timeliness of application, quality of care, cost containment, geographic location, patient availability, and acceptance of reimbursement allowance.

(v) *Limitation on authorized providers.* Where exclusive alternative delivery systems are established, only providers participating in the alternative delivery system are authorized providers of care. In such instances, the TDP shall continue to pay beneficiary claims for services rendered by otherwise authorized providers in accordance with established rules for reimbursement of nonparticipating providers where the beneficiary has established a patient relationship with the nonparticipating provider prior to the TDP's proposal to subcontract with the alternative delivery system.

(vi) *Charge agreements.* Where the alternative delivery system employs a discounted fee-for-service reimbursement methodology or schedule of charges or rates which includes all or most dental services and procedures recognized by the American Dental Association's Council on Dental Care Program's Code on Dental Procedures and Nomenclature, the discounts or schedule of charges or rates for all dental services and procedures shall be extended by its participating providers to beneficiaries of the TDP as an incentive for beneficiary participation in the alternative delivery system.

(g) *Benefit payment*—(1) *General.* TDP benefits payments are made either directly to the provider or to the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member, depending on the manner in which the claim is submitted or the terms of the subcontract of an alternative delivery system with the dental plan contractor.

(2) *Benefit payment.* Beneficiaries are not required to utilize participating providers. For beneficiaries who do use these participating providers, however, these providers shall not balance bill any amount in excess of the maximum payment allowed by the dental plan contractor for covered services. Beneficiaries using nonparticipating providers may be balance-billed amounts in excess of the dental plan contractor's determination of allowable charges. The following general requirements for the TDP benefit payment methodology shall be met, subject to modifications and exceptions approved

## Office of the Secretary of Defense

## § 199.13

by the Director, OCHAMPUS, or designee:

(i) Nonparticipating providers (or the Beneficiaries or active duty, Selected Reserve or Individual Ready Reserve members for unassigned claims) shall be reimbursed at the equivalent of not less than the 50th percentile of prevailing charges made for similar services in the same locality (region) or state, or the provider's actual charge, whichever is lower, subject to the exception listed in paragraph (e)(3)(ii) of this section, less any cost-share amount due for authorized services.

(ii) Participating providers shall be reimbursed in accordance with the contractor's network agreements, less any cost-share amount due for authorized services.

(3) *Fraud, abuse, and conflict of interest.* The provisions of §199.9 shall apply except for §199.9(e). All references to "CHAMPUS contractors", "CHAMPUS beneficiaries" and "CHAMPUS providers" in §199.9 shall be construed to mean the "dental plan contractor", "TDP beneficiaries" and "TPD providers" respectively for the purposes of this section. Examples of fraud include situations in which ineligible persons not enrolled in the TDP obtain care and file claims for benefits under the name and identification of a beneficiary; or when providers submit claims for services and supplies not rendered to Beneficiaries; or when a participating provider bills the beneficiary for amounts over the dental plan contractor's determination of allowable charges; or when a provider fails to collect the specified patient cost-share amount.

(h) *Appeal and hearing procedures.* The provisions of §199.10 shall apply except where noted in this section. All references to "CHAMPUS contractors", "CHAMPUS beneficiaries", "CHAMPUS participating providers" and "CHAMPUS Explanation of Benefits" in §199.10 shall be construed to mean the "dental plan contractor", "TDP beneficiaries", "TDP participating providers" and "Dental Explanation of Benefits or DEOB" respectively for the purposes of this section. References to "OCHAMPUSEUR" in §199.10 are not applicable to the TDP or this section.

(1) *General.* See §199.10(a).

(i) *Initial determination—(A) Notice of initial determination and right to appeal.* See §199.10(a)(1)(i).

(B) *Effect of initial determination.* See §199.10(a)(1)(ii).

(ii) *Participation in an appeal.* Participation in an appeal is limited to any party to the initial determination, including OCHAMPUS, the dental plan contractor, and authorized representatives of the parties. Any party to the initial determination, except OCHAMPUS and the dental plan contractor, may appeal an adverse determination. The appealing party is the party who actually files the appeal.

(A) *Parties to the initial determination.* See §§199.10(a)(2)(i) and 199.10(a)(2)(i)(A), (B), (C) and (E). In addition, a third party other than the dental plan contractor, such as an insurance company, is not a party to the initial determination and is not entitled to appeal, even though it may have an indirect interest in the initial determination.

(B) *Representative.* See §199.10(a)(2)(ii).

(iii) *Burden of proof.* See §199.10(a)(3).

(iv) *Evidence in appeal and hearing cases.* See §199.10(a)(4).

(v) *Late filing.* If a request for reconsideration, formal review, or hearing is filed after the time permitted in this section, written notice shall be issued denying the request. Late filing may be permitted only if the appealing party reasonably can demonstrate to the satisfaction of the dental plan contractor, or the Director, OCHAMPUS, or designee, that timely filing of the request was not feasible due to extraordinary circumstances over which the appealing party had no practical control. Each request for an exception to the filing requirement will be considered on its own merits. The decision of the Director, OCHAMPUS, or a designee, on the request for an exception to the filing requirement shall be final.

(vi) *Appealable issue.* See §§199.10(a)(6), 199.10(a)(6)(i), 199.10(a)(6)(iv), including §§199.10(a)(6)(iv)(A) and (C), and 199.10(a)(6)(v) for an explanation and examples of non-appealable issues. Other examples of issues that are not appealable under this section include:

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(A) The amount of the dental plan contractor-determined allowable charge since the methodology constitutes a limitation on benefits under the provisions of this section.

(B) Certain other issues on the basis that the authority for the initial determination is not vested in OCHAMPUS. Such issues include but are not limited to the following examples:

(1) A determination of a person's enrollment in the TDP is the responsibility of the dental plan contractor and ultimate responsibility for resolving a beneficiary's enrollment rests with the dental plan contractor. Accordingly, a disputed question of fact concerning a beneficiary's enrollment will not be considered an appealable issue under the provisions of this section, but shall be resolved in accordance with paragraph (c) of this section and the dental plan contractor's enrollment policies and procedures.

(2) Decisions relating to the issuance of a nonavailability statement (NAS) in each case are made by the Uniformed Services. Disputes over the need for an NAS or a refusal to issue an NAS are not appealable under this section. The one exception is when a dispute arises over whether the facts of the case demonstrate a dental emergency for which an NAS is not required. Denial of payment in this one situation is an appealable issue.

(3) Any decision or action on the part of the dental plan contractor to include a provider in their network or to designate a provider as participating is not appealable under this section. Similarly, any decision or action on the part of the dental plan contractor to exclude a provider from their network or to deny participating provider status is not appealable under this section.

(vii) *Amount in dispute*—(A) *General*. An amount in dispute is required for an adverse determination to be appealed under the provisions of this section, except as set forth or further explained in § 199.10(a)(7)(ii), (iii) and (iv).

(B) *Calculated amount*. The amount in dispute is calculated as the amount of money the dental plan contractor would pay if the services involved in the dispute were determined to be authorized benefits of the TDP. Examples

of amounts of money that are excluded by this section from payments for authorized benefits include, but are not limited to:

(1) Amounts in excess of the dental plan contractor's—determined allowable charge.

(2) The beneficiary's cost-share amounts.

(3) Amounts that the beneficiary, or parent, guardian, or other responsible person has no legal obligation to pay.

(4) Amounts excluded under the provisions of § 199.8 of this part.

(viii) *Levels of appeal*. See § 199.10(a)(8)(i). Initial determinations involving the sanctioning (exclusion, suspension, or termination) of TDP providers shall be appealed directly to the hearing level.

(ix) *Appeal decision*. See § 199.10(a)(9).

(2) *Reconsideration*. See § 199.10(b).

(3) *Formal review*. See § 199.10(c).

(4) *Hearing*—(i) *General*. See §§ 199.10(d) and 199.10(d)(1) through (d)(5) and (d)(7) through (d)(12) for information on the hearing process.

(ii) *Authority of the hearing officer*. The hearing officer, in exercising the authority to conduct a hearing under this part, will be bound by 10 U.S.C., chapter 55, and this part. The hearing officer in addressing substantive, appealable issues shall be bound by the dental benefits brochure applicable for the date(s) of service, policies, procedures, instructions and other guidelines issued by the ASD(HA), or a designee, or by the Director, OCHAMPUS, or a designee, in effect for the period in which the matter in dispute arose. A hearing officer may not establish or amend the dental benefits brochure, policy, procedures, instructions, or guidelines. However, the hearing officer may recommend reconsideration of the policy, procedures, instructions or guidelines by the ASD (HA), or a designee, when the final decision is issued in the case.

(5) *Final decision*. See §§ 199.10(e)(1) and 199.10(e)(1)(i) for information on final decisions in the appeal and hearing process, with the exception that no recommended decision shall be referred for review by ASD(HA).

(i) *Implementing Instructions*. The Director, TRICARE Management Activity or designee may issue TRICARE

Dental Program policies, standards, and criteria as may be necessary to implement the intent of this section.

[66 FR 12860, Mar. 1, 2001; 66 FR 16400, Mar. 26, 2001, as amended at 68 FR 65174, Nov. 19, 2003; 69 FR 55359, Sept. 14, 2004; 70 FR 55252, Sept. 21, 2005; 71 FR 1696, Jan. 11, 2006; 71 FR 66872, Nov. 17, 2006; 72 FR 53685, Sept. 20, 2007; 76 FR 57643, Sept. 16, 2011; 76 FR 81367, Dec. 28, 2011]

**§ 199.14 Provider reimbursement methods.**

(a) *Hospitals.* The CHAMPUS-determined allowable cost for reimbursement of a hospital shall be determined on the basis of one of the following methodologies.

(1) *CHAMPUS Diagnosis Related Group (DRG)-based payment system.* Under the CHAMPUS DRG-based payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system is made on the basis of prospectively-determined rates and applied on a per discharge basis using DRGs. Payments under this system will include a differentiation for urban (using large urban and other urban areas) and rural hospitals and an adjustment for area wage differences and indirect medical education costs. Additional payments will be made for capital costs, direct medical education costs, and outlier cases.

(i) *General—(A) DRGs used.* The CHAMPUS DRG-based payment system will use the same DRGs used in the most recently available grouper for the Medicare Prospective Payment System, except as necessary to recognize distinct characteristics of CHAMPUS beneficiaries and as described in instructions issued by the Director, OCHAMPUS.

(B) *Assignment of discharges to DRGs.*

(1) The classification of a particular discharge shall be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed and discharge status. In addition, for neonatal cases (other than normal newborns) the classification shall also account for birth-weight, surgery and the presence of multiple, major and other neonatal

problems, and shall incorporate annual updates to these classification features.

(2) Each discharge shall be assigned to only one DRG regardless of the number of conditions treated or services furnished during the patient's stay.

(C) *Basis of payment—(1) Hospital billing.* Under the CHAMPUS DRG-based payment system, hospitals are required to submit claims (including itemized charges) in accordance with § 199.7(b). The CHAMPUS fiscal intermediary will assign the appropriate DRG to the claim based on the information contained in the claim. Any request from a hospital for reclassification of a claim to a higher weighted DRG must be submitted, within 60 days from the date of the initial payment, in a manner prescribed by the Director, OCHAMPUS.

(2) *Payment on a per discharge basis.* Under the CHAMPUS DRG-based payment system, hospitals are paid a pre-determined amount per discharge for inpatient hospital services furnished to CHAMPUS beneficiaries.

(3) *Pricing of claims.* All final claims with discharge dates of September 30, 2014, or earlier that are reimbursed under the CHAMPUS DRG-based payment system are to be priced as of the date of admission, regardless of when the claim is submitted. All final claims with discharge dates of October 1, 2014, or later that are reimbursed under the CHAMPUS DRG-based payment system are to be priced as of the date of discharge.

(4) *Payment in full.* The DRG-based amount paid for inpatient hospital services is the total CHAMPUS payment for the inpatient operating costs (as described in paragraph (a)(1)(i)(C)(5) of this section) incurred in furnishing services covered by the CHAMPUS. The full prospective payment amount is payable for each stay during which there is at least one covered day of care, except as provided in paragraph (a)(1)(iii)(E)(I)(i)(A) of this section.

(5) *Inpatient operating costs.* The CHAMPUS DRG-based payment system provides a payment amount for inpatient operating costs, including:

(i) Operating costs for routine services, such as the costs of room, board, and routine nursing services;