

Dental Benefit Details

2024

This document provides additional details about the supplemental dental benefits that are covered under our plan. For more information about this document or your dental benefits, please contact Member Services at the phone number or web address shown on the back cover of the *Evidence of Coverage* or on your Member ID card.

The *Dental Benefit Details* applies to the plan benefit packages shown below. The plan benefit package is on the cover of the *Evidence of Coverage*, on the lower right corner.

State	Plan Benefit Package	Plan Name
CA	H0562039000	Wellcare Premium Ultra (HMO)
CA	H0562079000	Wellcare No Premium Ruby (HMO)
CA	H0562009000	Wellcare Premium Ultra (HMO)
CA	H0562092000	Wellcare Specialty No Premium (HMO C-SNP)
CA	H0562097000	Wellcare No Premium Focus (HMO)
CA	H0562012000	Wellcare No Premium Focus (HMO)
CA	H0562130001	Wellcare Low Premium (HMO)
CA	H0562130002	Wellcare Low Premium (HMO)
CA	H0562125000	Wellcare No Premium Focus (HMO)
CA	H0562126000	Wellcare No Premium Focus (HMO)
CA	H0562128000	Wellcare No Premium (HMO)

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Covered Dental Benefits: Our plan provides coverage for the dental services described below. Refer to your 2024 *Evidence of Coverage* for any applicable cost sharing.

Dental 2024 Schedule of Benefits

Category	Dental Code	Procedure Description	Frequency
Diagnostic (Preventive) Services			
Oral Exam	D0120	Routine periodic exam completed during check-up	2 (D0120) per 12 months; not within 6 months of D0150
Oral Exam	D0140	Limited exam to evaluate a problem	2 (D0140) per 12 months
Oral Exam	D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	Unlimited
Oral Exam	D0150	Comprehensive exam (for a new patient, or an established patient after 3 or more years of inactivity from dental treatment)	1 (D0150) every 36 months; not within 36 months of D0120
Oral Exam	D0170	Limited re-evaluation of a problem	2 (D0170) every 12 months
Oral Exam	D0171	Re-evaluation for post-operative office visit	2 (D0171) every 12 months
Oral Exam	D0180	Comprehensive periodontal evaluation (for a new patient, or an established patient)	2 (D0180) every 12 months; not on same date as D0120 or D0150
Dental X-Rays	D0210	Full mouth/complete x-ray set for evaluation of the teeth and mouth	1 (D0210) every 24 months
Dental X-Rays	D0220	X-rays for closer evaluation around the roots of teeth	Unlimited
Dental X-Rays	D0230	X-rays for closer evaluation around the roots of teeth	Unlimited
Dental X-Rays	D0240	Intraoral, occlusal radiographic image	Unlimited
Dental X-Rays	D0250	Extra-oral 2D projection radiographic image created using a stationary radiation source and detector	Unlimited
Dental X-Rays	D0251	Extra-oral posterior dental radiographic image	Unlimited

Category	Dental Code	Procedure Description	Frequency
Dental X-Rays	D0270	Bitewing x-rays for evaluation of the teeth and bone (single radiographic image)	4 (D2070) every 12 months
Dental X-Rays	D0272	Bitewing x-rays for evaluation of the teeth and bone (two radiographic images)	2 (D0272) every 12 months
Dental X-Rays	D0273	Bitewing x-rays for evaluation of the teeth and bone (three radiographic images)	2 (D0273) every 12 months
Dental X-Rays	D0274	Bitewing x-rays for evaluation of the teeth and bone (four radiographic images)	1 (D0274) every 12 months
Dental X-Rays	D0277	Bitewing x-rays for evaluation of the teeth and bone (vertical bitewings - 7 to 8 radiographic images)	Unlimited
Dental X-Rays	D0330	Whole-mouth x-ray for evaluation of the teeth and mouth (panoramic radiographic image)	Unlimited
Dental X-Rays	D0350	2-Dimensional photo or x-ray image	Unlimited
Dental X-Rays	D0372	Intraoral tomosynthesis – comprehensive series of radiographic images	1 (D0372) every 24 months
Dental X-Rays	D0373	Intraoral tomosynthesis – bitewing radiographic image	1 (D0373) every 12 months
Dental X-Rays	D0374	Intraoral tomosynthesis – periapical radiographic image	Unlimited
Dental X-Rays	D0387	Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	1 (D0387) every 24 months
Dental X-Rays	D0388	Intraoral tomosynthesis – bitewing radiographic image – image capture only	1 (D0388) every 12 months
Dental X-Rays	D0389	Intraoral tomosynthesis – periapical radiographic image – image capture only	Unlimited
Other Services	D0460	Tooth nerve test	Unlimited
Other Services	D0470	Diagnostic casts	Unlimited

Category	Dental Code	Procedure Description	Frequency
Other Services	D0472- D0474	Accession of tissue	Unlimited
Other Services	D0486	Laboratory accession of transepithelial cytologic sample, micro exam, preparation and transmission of written report	Unlimited
Other Services	D0600	Non-ionizing diagnostic procedure	Unlimited
Dental X-Rays	D0701	Whole-mouth and 2-Dimensional x-ray images of the head (panoramic radiographic image - image capture only)	Unlimited
Dental X-Rays	D0702	Whole-mouth and 2-Dimensional x-ray images of the head (2-D cephalometric radiographic image - image capture only)	Unlimited
Dental Photos	D0703	Photo images, image capture only	Unlimited
Dental X-Rays	D0705	X-rays taken outside the mouth	Unlimited
Dental X-Rays	D0706	X-rays taken inside the mouth	Unlimited
Dental X-Rays	D0707	X-rays for closer evaluation around the roots of teeth – image capture only	Unlimited
Dental X-Rays	D0708	Bitewing x-rays for evaluation of the teeth and bone – image capture only	4 (D0708) every 12 months
Dental X-Rays	D0709	Full-mouth/Complete x-ray set for evaluation of the teeth and mouth – image capture only	1 (D0709) every 24 months
Dental X-Rays	D0801	3D dental surface scan – direct	Unlimited
Dental X-Rays	D0802	3D dental surface scan - indirect	Unlimited
Dental X-Rays	D0803	3D facial surface scan – direct	Unlimited
Dental X-Rays	D0804	3D facial surface scan – indirect	Unlimited
Other Services	D0999	Unspecified diagnostic procedure, by report	Unlimited
Preventive Services			
Other Services	D1110	Standard adult dental cleaning	2 (D1110) every 12 months
Other Services	D1120	Standard child dental cleaning	2 (D1120) every 12 months

Category	Dental Code	Procedure Description	Frequency
Fluoride	D1206	Fluoride treatment	1 (D1206) every 12 months
Other Services	D1310	Nutritional counseling for control of dental disease	Unlimited
Other Services	D1330	Oral hygiene instructions	Unlimited
Other Services	D1351	Sealant per tooth	Unlimited
Other Services	D1353	Sealant repair – per tooth	Unlimited
Other Services	D1354	Interim caries arresting medicament application	Unlimited
Other Services	D1510	Space Maintainer – Fixed (unilateral - per quadrant)	Unlimited
Other Services	D1516	Space Maintainer – Fixed (bilateral, maxillary)	Unlimited
Other Services	D1517	Space Maintainer – Fixed (bilateral, mandibular)	Unlimited
Other Services	D1520	Space Maintainer – Removable (unilateral - per quadrant)	Unlimited
Other Services	D1526	Space Maintainer – Removable (bilateral, maxillary)	Unlimited
Other Services	D1527	Space Maintainer – Removable (bilateral, mandibular)	Unlimited
Other Services	D1551- D1553	Re-cement or re-bond bilateral space maintainer (D1551 - maxillary, D1552 - mandibular, D1553 - per quadrant)	Unlimited
Other Services	D1556- D1558	Removal of fixed space maintainer (D1557 - maxillary, D1558 - mandibular, D1556 - per quadrant)	Unlimited
Other Services	D1575	Distal shoe space maintainer - fixed unilateral (per quadrant)	Unlimited
Other Services	D1701, D1702, D1708, D1709, D1713, D1714	Pfizer – Covid-19 vaccine administration (first, second, third, booster, tris-sucrose pediatric-first, and tris-sucrose pediatric-second dose)	Unlimited

Category	Dental Code	Procedure Description	Frequency
Other Services	D1703, D1704, D1710, D1711	Moderna – Covid-19 vaccine administration (first, second, third, and booster dose)	Unlimited
Other Services	D1705, D1706	AstraZeneca – Covid-19 vaccine administration (first and second dose)	Unlimited
Other Services	D1707	Janssen – Covid-19 vaccine administration	Unlimited
Other Services	D1781- D1783	Vaccine administration – human papillomavirus (Dose 1, 2 & 3)	Unlimited
Comprehensive Restorative (Fillings and Crowns) Services			
Restorative	D2140- D2394	Metal or tooth-colored fillings placed directly into the mouth on front, middle, or back teeth	Unlimited
Restorative	D2510- D2530	Inlay – metallic, filling that fits into the pits and grooves of a tooth’s chewing surface	1 (D2510, D2520, D2530) every 60 months
Restorative	D2542- D2544; D2740- D2794	Cap (crown) or partial crown called an onlay – made of metal, porcelain/ceramic, porcelain fused to metal, or titanium. Made outside the mouth and then placed into the mouth.	1 (D2542-D2544; D2740, D2750-D2753; D2780-D2783; D2790-D2792; D2794) every 60 months
Restorative	D2910, D2915, D2920	Re-cementing or re-bonding a crown that has fallen off	Unlimited
Restorative	D2930, D2931	Pre-made crowns	1 (D2930, D2931) every 60 months
Restorative	D2940	Protective filling	Unlimited
Restorative	D2950- D2955	Buildup of filling around a post to prepare the tooth for a crown	Unlimited
Restorative	D2962	Labial veneer (porcelain laminate) – laboratory	Unlimited
Comprehensive Endodontic (Root Canal Treatment) Services			
Endodontics	D3110, D3120	Pulp capping	Unlimited
Endodontics	D3220- D3221	Pulpotomy	

Category	Dental Code	Procedure Description	Frequency
Endodontics	D3230, D3240, D3310, D3320, D3330, D3332	Root canal treatment	
Endodontics	D3346- D3348	Root canal retreatment of failed previous root canal	Unlimited
Endodontics	D3351- D3353; D3410, D3421; D3425- D3426; D3430; D3450	Tooth root-tip repairs	Unlimited
Endodontics	D3471- D3473	Surgical repair of root resorption	Unlimited
Endodontics	D3911	Intraorifice barrier	Unlimited
Endodontics	D3920	Other root canal procedure	Unlimited
Comprehensive Periodontal (Gum Treatment) Services			
Periodontics	D4210, D4211, D4240, D4241	Gum tissue surgery	1 (D4210, D4211, D4240, D4241) every 36 months
Periodontics	D4249	Clinical crown lengthening - hard tissue	1 (D4249) per lifetime
Periodontics	D4260, D4261, D4270, D4273, D4274, D4283	Gum tissue surgery	1 (D4260, D4261, D4270, D4273, D4274, D4283) every 36 months
Periodontics	D4341	Deep cleaning for 4 or more teeth in a mouth	Only 1 of any (D4341-D4342) per quadrant every 12 months; only two quadrants allowed on same date of service
Periodontics	D4342	Deep cleaning for 1-3 teeth in a mouth	Only 1 of any (D4341-D4342) per quadrant every 12 months; only two quadrants

Category	Dental Code	Procedure Description	Frequency
			allowed on same date of service
Periodontics	D4346	Scaling for moderate or severe swollen or infected gums, full mouth, after evaluation	2 (D4346) every 12 months
Periodontics	D4355	Cleaning buildup off the teeth to allow for proper visibility of the teeth for examination	Unlimited
Periodontics	D4381	Medicine applied to gum space around a tooth (per tooth) for management of gum disease	Unlimited
Periodontics	D4910	Routine dental cleaning for an adult who has documented history of gum disease	2 (D4910) every 12 months; not within 90 days of D1110
Periodontics	D4999	Unspecified periodontal procedure, by report	Unlimited
Comprehensive Removable Prosthodontic (Denture) Services			
Removable Prosthodontics	D5110- D5120	Complete dentures – upper and/or lower	Only 1 of any (D5110-D5228) per arch every 60 months
Removable Prosthodontics	D5130- D5140	Immediate complete dentures – upper and/or lower, placed at time of extracting remaining teeth	
Removable Prosthodontics	D5211- D5214	Partial dentures – upper and/or lower, resin, metal, or flexible base	
Removable Prosthodontics	D5221- D5224, D5227, D5228	Immediate partial dentures – upper and/or lower, resin, metal, or flexible base, placed at time of tooth extractions	
Removable Prosthodontics	D5410, D5411, D5421, D5422, D5511, D5512, D5611, D5612, D5621, D5622, D5630	Adjust or repair complete or partial dentures	Unlimited

Category	Dental Code	Procedure Description	Frequency
Removable Prosthodontics	D5520, D5640	Replace missing or broken parts of complete or partial dentures	Unlimited
Removable Prosthodontics	D5650	Add tooth to existing partial denture	Unlimited
Removable Prosthodontics	D5660	Add clasp to existing partial denture - per tooth	Unlimited
Removable Prosthodontics	D5710-D5761	Reline or rebase complete and/or partial dentures – upper and/or lower	Only 1 of any (D5710-D5761) per arch every 12 months
Removable Prosthodontics	D5765	Soft liner for complete or partial removable denture - indirect	Unlimited
Removable Prosthodontics	D5810-D5821	Interim/temporary denture	Only 1 of any (D5810-D5821) per arch every 60 months
Removable Prosthodontics	D5850, D5851	Liner to help heal gum tissue under a denture	Unlimited
Removable Prosthodontics	D5876	Add metal substructure to acrylic full denture (per arch)	1 (D576) every 12 months

Comprehensive Fixed Prosthodontic (Bridges) Services

Fixed Prosthodontics	D6210-D6245	Part of the bridge that is the fake tooth, replacing the missing tooth (pontic)	1 (D6210-D6245) every 60 months
Fixed Prosthodontics	D6750-D6753, D6780-D6782, D6784, D6790-D6794	Crowns and partial crowns that are placed on teeth supporting a bridge (retainer crowns)	1 (D6750, D6753, D6780-D6782; D6784, D6790-D6794) every 60 months
Fixed Prosthodontics	D6930	Re-cement or re-bond a bridge that comes out	Unlimited

Comprehensive Oral Surgery (Extraction) Services

Other Oral/Maxillofacial Surgery	D7111, D7140-D7251	Extractions	1 (D7111, D7140-D7251) per tooth per lifetime
Other Oral/Maxillofacial Surgery	D7270, D7280	Surgery to move or re-implant natural teeth	Unlimited

Category	Dental Code	Procedure Description	Frequency
Other Oral/Maxillofacial Surgery	D7285, D7286	Biopsies	Unlimited
Other Oral/Maxillofacial Surgery	D7310-D7321	Reshaping of the bone that surrounds the teeth or tooth spaces	Unlimited
Other Oral/Maxillofacial Surgery	D7510, D7511	Cleaning an abscess/infection from a tooth root	Unlimited
Other Oral/Maxillofacial Surgery	D7961-D7963	Other surgical procedures to remove excess gum tissue or muscle attachments	Unlimited
Other Oral/Maxillofacial Surgery	D7971	Excision of pericoronal gingiva	Unlimited
Other Oral/Maxillofacial Surgery	D8070	Comprehensive orthodontic treatment of the transitional dentition	Unlimited
Other Oral/Maxillofacial Surgery	D8080	Comprehensive orthodontic treatment of the adolescent dentition	Unlimited
Other Oral/Maxillofacial Surgery	D8090	Comprehensive orthodontic treatment of the adult dentition	Unlimited
Other Oral/Maxillofacial Surgery	D8660	Pre-orthodontic treatment examination to monitor growth and development	Unlimited
Other Oral/Maxillofacial Surgery	D8670	Periodic orthodontic treatment visit	Unlimited
Other Oral/Maxillofacial Surgery	D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Unlimited
Other Oral/Maxillofacial Surgery	D8681	Removable orthodontic retainer adjustment	Unlimited
Other Oral/Maxillofacial Surgery	D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	Unlimited
Other Oral/Maxillofacial Surgery	D8698	Re-cement or re-bond fixed retainer - maxillary	Unlimited

Category	Dental Code	Procedure Description	Frequency
Other Oral/Maxillofacial Surgery	D8699	Re-cement or re-bond fixed retainer - mandibular	Unlimited
Other Oral/Maxillofacial Surgery	D8999	Unspecified orthodontic procedure, by report	Unlimited
Comprehensive Other Adjunctive (Non-Routine) Services			
Other Comprehensive Services	D9110	Minor procedure for emergency treatment of dental pain	Unlimited
Other Comprehensive Services	D9120	Cutting an old bridge to help remove it	Unlimited
Other Comprehensive Services	D9210- D9211, D9215- D9233	Deep sedation/general anesthesia	Unlimited
Other Comprehensive Services	D9239, D9243	Intravenous moderate (conscious) sedation/analgesia	Unlimited
Other Comprehensive Services	D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	Unlimited
Other Comprehensive Services	D9311	Consultation with a medical health care professional	Unlimited
Other Comprehensive Services	D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	Unlimited
Other Comprehensive Services	D9440	Office visit - after regularly scheduled hours	Unlimited
Other Comprehensive Services	D9630	Fluoride rinses and other prescription dental products for home use	Unlimited
Other Comprehensive Services	D9910	Application of desensitizing medicament	Unlimited

Category	Dental Code	Procedure Description	Frequency
Other Comprehensive Services	D9912	Pre-visit patient screening	Unlimited
Other Comprehensive Services	D9942	Bite guard repair	Unlimited
Other Comprehensive Services	D9943- D9946	Bite guard, hard or soft appliance	Unlimited
Other Comprehensive Services	D9947	Custom sleep apnea appliance fabrication and placement	Unlimited
Other Comprehensive Services	D9948	Adjustment of custom sleep apnea appliance	Unlimited
Other Comprehensive Services	D9949	Repair of custom sleep apnea appliance	Unlimited
Other Comprehensive Services	D9951, D9952	Minor adjustment of bite	Unlimited
Other Comprehensive Services	D9953	Reline custom sleep apnea appliance (indirect)	Unlimited
Other Comprehensive Services	D9961	Duplicate/copy patient's records	Unlimited
Other Comprehensive Services	D9972	External bleaching-per arch-performed in office	Unlimited
Other Comprehensive Services	D9995	Teledentistry - performed in real time	Unlimited
Other Comprehensive Services	D9996	Teledentistry - performed when information stored and sent to a dentist for later review	
Other Comprehensive Services	D9999	Unspecified adjunctive procedure, by report	Unlimited

General Limitations:

1. Any procedures not specifically listed as a covered benefit in this Plan's Schedule of Benefits are available at 100% of the usual and customary fees of the treating Health Net selected general or specialty care dentist.
2. Dental procedures or services performed solely for cosmetic purposes or solely for appearance are available at 100% of the usual and customary fees of the treating Health Net selected general or specialty care dentist, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits.
3. General anesthesia is a covered benefit only when administered by the treating dentist, in conjunction with oral and periodontal surgical procedures.

Exclusions:

1. Services performed by any dentist not contracted with Health Net, without prior approval (except out-of-area emergency services). This includes services performed by a general dentist or specialty care dentist.
2. Dental procedures started prior to the member's eligibility under this Plan or started after the member's termination from the Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken.
3. Any dental services, or appliances, which are determined to be not reasonable and/ or necessary for maintaining or improving the member's dental health, as determined by the Health Net selected general dentist.
4. Orthognathic surgery.
5. Inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
6. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged due to abuse, misuse, or neglect.
7. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits. Any services related to pathology laboratory fees.
8. Procedures, appliances, or restorations whose primary main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits.
9. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
10. Dental services required while serving in the Armed Forces of any country or international authority.
11. Dental services considered experimental in nature.
12. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member.
13. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

14. Foreign services are not covered unless required as an emergency.

Orthodontic Benefit Limitations and Exclusions:

1. Orthodontic treatment must be provided by a Health Net selected general dentist or Health Net contracted orthodontist in order for the co-payments listed in this Plan's Schedule of Benefits to apply.
2. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a charge of \$25 per visit.
3. The following are not included as orthodontic benefits:
 - A. Repair or replacement of lost or broken appliances;
 - B. Retreatment of orthodontic cases;
 - C. Treatment involving:
 - i. Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
 - ii. Hormonal imbalances or other factors affecting growth or developmental abnormalities;
 - iii. Treatment related to temporomandibular joint disorders;
 - iv. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.
5. Active orthodontic treatment in progress on your effective date of coverage is not covered. Active orthodontic treatment means tooth movement has begun.