Dental Benefit Details

2027

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	H3561009000	Wellcare Health Net Dual Liberty (HMO D-SNP)
CA	H3561010001	Wellcare Health Net Dual Align (HMO D-SNP)
CA	H3561010002	Wellcare Health Net Dual Align (HMO D-SNP)

Covered Dental Benefits: Our plan provides coverage for the dental services described below. Refer to your 2027 *Evidence of Coverage* for any applicable cost sharing.

Dental 2027 Schedule of Benefits

Code	Code description	Periodicity
Diagnostic (Preventive) Services		
D0140	Limited Oral Evaluation	1 of (D0140) every calendar year
Restorative Services		
D2750	Crown - porcelain fused to high noble metal	1 of (D2750-D2792, D6240-D6752) per tooth every 7 calendar years
D2752	Crown, porcelain fused to noble metal	1 of (D2750-D2792, D6240-D6752) per tooth every 7 calendar years
D2790	Crown - full cast high noble metal	1 of (D2750-D2792, D6240-D6752) per tooth every 7 calendar years
D2792	Crown, full cast noble metal	1 of (D2750-D2792, D6240-D6752) per tooth every 7 calendar years
Prosthodontics (Removable) Services		
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	1 of (D5670, D5671) per arch every 3 calendar years
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	1 of (D5670, D5671) per arch every 3 calendar years
D5710	Rebase complete maxillary denture	1 of (D5710-D5721) per arch every 2 calendar years
D5711	Rebase complete mandibular denture	1 of (D5710-D5721) per arch every 2 calendar years

Code	Code description	Periodicity
D5720	Rebase maxillary partial denture	1 of (D5710-D5721) per arch every 2 calendar years
D5721	Rebase mandibular partial denture	1 of (D5710-D5721) per arch every 2 calendar years
Prosthodontics (Fixed) Services		
D6240	Pontic - porcelain fused to high noble metal	1 of (D2750-D2792, D6240-D6752) per tooth every 7 calendar years
D6242	Pontic, porcelain fused to noble metal	1 of (D2750-D2792, D6240-D6752) per tooth every 7 calendar years
D6750	Crown - Porcelain Fused To High Noble Metal	1 of (D2750-D2792, D6240-D6752) per tooth every 7 calendar years
D6752	Retainer crown, porcelain fused to noble metal	1 of (D2750-D2792, D6240-D6752) per tooth every 7 calendar years
Adjunctive General Services		
D9310	Consultation, other than requesting dentist	1 (D9310) every calendar year

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 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, 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, 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 for 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.

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