Dental Benefit Details

2027

This document provides additional details about the supplemental dental benefits that are covered under our plan. The *Dental Benefit Details* applies to the 2027 plan benefit packages shown on the following page(s). 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 2027 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
AR	H9630010000	Wellcare Arkansas Total Care Dual Access (HMO-POS D-SNP)
AZ	H0351038000	Wellcare Specialty Simple (HMO C-SNP)
CT	H0712005000	Wellcare Dual Access (HMO-POS D-SNP)
DE	H4661001000	Wellcare Simple (HMO-POS)
GA	H0111001000	Wellcare Simple Open (PPO)
GA	H0111007000	Wellcare Patriot Giveback Open (PPO)
GA	H1112038000	Wellcare Simple (HMO-POS)
GA	H1112044000	Wellcare Simple (HMO-POS)
GA	H1112048000	Wellcare Peach State Health Plan Dual Reserve (HMO-POS D-SNP)
IN	H6348002000	Wellcare Simple Open (PPO)
KY	H9730007000	Wellcare Giveback (HMO-POS)
MI	H5475038000	Wellcare Assist (HMO-POS)
NC	H1914011000	Wellcare Patriot Giveback Open (PPO)
NE	H1215001000	Wellcare Nebraska Total Care Dual Liberty Sync (HMO-POS D-SNP)
NY	H5599002000	Wellcare Fidelis Assist (HMO-POS)
TX	H5294017000	Wellcare Simple (HMO)
TX	H5294018000	Wellcare Simple (HMO)
TX	H0174022000	Wellcare Superior HealthPlan Dual Reserve (HMO D-SNP)

Disclaimers:

Texas (H0174, H5294): As a Wellcare HMO D-SNP member, you have coverage for both Medicare and Medicaid. You will receive your Medicare health care and prescription drug benefits through Wellcare. You are also eligible to receive additional health care benefits through STAR+PLUS Medicaid. You can learn more about providers who participate in Wellcare and Medicaid by visiting https://www.wellcarefindaprovider.com/navigate-a-network.html. To request written copies of our Medicare and Medicaid Provider Directories, please contact us at H0174: 1-833-444-9089 / H5294: 1-855-445-3556 (TTY: 711), or reach out to your STAR+PLUS Managed Care Organization (MCO).

Please contact your plan for details.

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 and benefit maximum.

Dental 2027 Schedule of Benefits

Code	General Service Description	Periodicity	Prior Auth
Diagnostic (Preventive) Services			
D0120	Periodic Oral Evaluation	2 of (D0120) every plan year, not within 6 months of D0150.	**N**
D0140	Limited Oral Evaluation	2 of (D0140, D0160, D9310) every plan year.	**N**
D0150	Comprehensive oral evaluation	1 of (D0150) every 3 plan years, not within 3 plan years of D0120.	**N**
D0160	Oral evaluation, problem focused	2 of (D0140, D0160, D9310) every plan year.	**N**
D0180	Comprehensive Periodontal Evaluation	2 of (D0180) every plan year, not on same date as D0120 or D0150.	**N**
D0210	Intraoral, complete series of radiographic images	1 of (D0210, D0330, D0701, D0709) every 3 plan years.	**N**
D0220	Intraoral, periapical, first radiographic image	1 of (D0220) per date of service. Maximum number of x-rays on a single date of service limited to a complete mouth series.	**N**

Code	General Service Description	Periodicity	Prior Auth
D0230	Intraoral, periapical, each add additional radiographic image	4 of (D0230) per date of service. Maximum reimbursement for x-rays on a single date of service limited to the allowed reimbursement for a complete mouth series.	**N**
D0240	Intraoral, occlusal radiographic image	1 of (D0240) every plan year.	**N**
D0251	Extra-oral posterior dental radiographic image	2 of (D0251) every plan year.	**N**
D0270	Bitewing, single radiographic image	2 of (D0270-D0277) every plan year. Maximum reimbursement for a single date of service limited to the allowed reimbursement for a complete mouth series.	**N**
D0272	Bitewings, two radiographic images	2 of (D0270-D0277) every plan year. Maximum reimbursement for a single date of service limited to the allowed reimbursement for a complete mouth series.	**N**
D0273	Bitewings, three radiographic images	2 of (D0270-D0277) every plan year. Maximum reimbursement for a single date of service limited to the allowed reimbursement for a complete mouth series.	**N**
D0274	Bitewings, four radiographic images	2 of (D0270-D0277) every plan year. Maximum reimbursement for a single date of service limited to the allowed reimbursement for a complete mouth series.	**N**

Code	General Service Description	Periodicity	Prior Auth
D0277	Vertical bitewings – 7 to 8 radiographic images	2 of (D0270-D0277) every plan year. Maximum reimbursement for a single date of service limited to the allowed reimbursement for a complete mouth series.	**N**
D0330	Panoramic radiographic image	1 of (D0210, D0330, D0701, D0709) every 3 plan years. Maximum reimbursement for a single date of service limited to the allowed reimbursement for a complete mouth series.	**N**
D0350	2D oral/facial photographic image, intra-orally/extra-orally	1 of (D0350) every 3 plan years.	**N**
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of image, including report	1 of (D0391) per date of service; allowed only when submitted along with (D0701, D0703, D0706-D0709).	**N**
D0460	Pulp Vitality Test	1 of (D0460) per visit.	**N**
D0701	Panoramic radiographic image - image capture only	1 of (D0210, D0330, D0701, D0709) every 3 plan years	**N**
D0703	2-D photographic image - image capture only	1 of (D0703) every 3 plan years	**N**
D0706	Intraoral - occlusal radiographic image - image capture only	2 of (D0706) every plan year	**N**
D0707	Intraoral - periapical radiographic image - image capture only	1 of (D0707) per date of service	**N**
D0708	Intraoral - bitewing radiographic image - image capture only	2 of (D0708) every plan year	**N**
D0709	Intraoral - complete series of radiograpic images - image capture only	1 of (D0210, D0330, D0701, D0709) every 3 plan years	**N**
D1110	Prophylaxis, adult	2 of (D1110) every plan year	**N**
D1206	Fluoride varnish	1 of (D1206, D1208) every plan year	**N**

Code	General Service Description	Periodicity	Prior Auth
D1208	Topical application of fluoride, excluding varnish	1 of (D1206, D1208) every plan year	**N**
D1355	Application of a caries preventive medicament	One of (D1355) per tooth per 6 months.	**N**
Restorative			
D2140	Amalgam, one surface, primary or permanent	1 of (D2140-D2335, D2391 - D2394) per surface, per tooth, every 2 plan years.	**N**
D2150	Amalgam, two surfaces, primary or permanent	1 of (D2140-D2335, D2391 - D2394) per surface, per tooth, every 2 plan years.	**N**
D2160	Amalgam, three surfaces, primary or permanent	1 of (D2140-D2335, D2391 - D2394) per surface, per tooth, every 2 plan years.	**N**
D2161	Amalgam, four or more surfaces, primary or permanent	1 of (D2140-D2335, D2391 - D2394) per surface, per tooth, every 2 plan years.	**N**
D2330	Resin-based composite, one surface, anterior	1 of (D2140-D2335, D2391 - D2394) per surface, per tooth, every 2 plan years.	**N**
D2331	Resin-based composite, two surfaces, anterior	1 of (D2140-D2335, D2391 - D2394) per surface, per tooth, every 2 plan years.	**N**
D2332	Resin-based composite, three surfaces, anterior	1 of (D2140-D2335, D2391 - D2394) per surface, per tooth, every 2 plan years.	**N**
D2335	Resin-based composite, four or more surfaces, involving incisal angle	1 of (D2140-D2335, D2391 - D2394) per surface, per tooth, every 2 plan years.	**N**
D2390	Resin-based composite crown, anterior	1 of (D2390) per tooth, every 2 plan years. Must have at least 50% remaining bone support.	**N**
D2391	Resin-based composite, one surface, posterior	1 of (D2140-D2335, D2391 - D2394) per surface, per tooth, every 2 plan years.	**N**

Code	General Service Description	Periodicity	Prior Auth
D2392	Resin-based composite, two surfaces, posterior	1 of (D2140-D2335, D2391 - D2394) per surface, per tooth, every 2 plan years.	**N**
D2393	Resin-based composite, three surfaces, posterior	1 of (D2140-D2335, D2391 - D2394) per surface, per tooth, every 2 plan years.	**N**
D2394	Resin-based composite, four or more surfaces, posterior	1 of (D2140-D2335, D2391 - D2394) per surface, per tooth, every 2 plan years.	**N**
D2740	Crown, porcelain/ceramic	1 of (D2740-D2752, D2790-D2792 per tooth every 7 year period. Requires extensive loss of tooth structure due to decay or fracture and at least 50% remaining bone support.	**Y**
D2750	Crown - porcelain fused to high noble metal	1 of (D2740-D2752, D2790-D2792 per tooth every 7 year period. Requires extensive loss of tooth structure due to decay or fracture and at least 50% remaining bone support.	**Y**
D2751	Crown, porcelain fused to predominantly base metal	1 of (D2740-D2752, D2790-D2792 per tooth every 7 year period. Requires extensive loss of tooth structure due to decay or fracture and at least 50% remaining bone support.	**Y**
D2752	Crown, porcelain fused to noble metal	1 of (D2740-D2752, D2790-D2792 per tooth every 7 year period. Requires extensive loss of tooth structure due to decay or fracture and at least 50% remaining bone support.	**Y**
D2790	Crown - full cast high noble metal	1 of (D2740-D2752, D2790-D2792 per tooth every 7 year period. Requires extensive loss of tooth structure due to decay	**Y**

Code	General Service Description	Periodicity	Prior Auth
		or fracture and at least 50% remaining bone support.	
D2791	Crown, full cast predominantly base metal	1 of (D2740-D2752, D2790-D2792 per tooth every 7 year period. Requires extensive loss of tooth structure due to decay or fracture and at least 50% remaining bone support.	**Y**
D2792	Crown, full cast noble metal	1 of (D2740-D2752, D2790-D2792 per tooth every 7 year period. Requires extensive loss of tooth structure due to decay or fracture and at least 50% remaining bone support.	**Y**
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	1 of (D2910-D2920) per tooth every plan year; not covered within 6 months of delivery.	**N**
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	1 of (D2910-D2920) per tooth every plan year; not covered within 6 months of delivery.	**N**
D2920	Re-cement or re-bond crown	1 of (D2910-D2920) per tooth every plan year; not covered within 6 months of delivery.	**N**
D2950	Core buildup, including any pins when required	1 of (D2950, D2952-D2954, D2957) per tooth every 7 plan years. Must be necessary to provide retention for an approved crown.	**Y**
D2951	Pin retention, per tooth, in addition to restoration	1 of (D2951) per tooth every 7 plan years.	**N**
D2952	Post and core in addition to crown, indirectly fabricated	Not Covered	**Y**
D2953	Each additional indirectly fabricated post, same tooth	Not Covered	**Y**
D2954	Prefabricated post and core in addition to crown	Not Covered	**Y**

Code	General Service Description	Periodicity	Prior Auth
D2957	Each additional prefabricated post, same tooth	Not Covered	**N**
D2980	Crown repair necessitated by restorative material failure	1 of (D2980) per tooth every 3 plan years.	**N**
Endodontics			
D3120	Pulp cap, indirect (excluding final restoration)	1 of (D3110, D3120, D3220) per tooth per lifetime; requires at least 50% remaining bone support.	**N**
Periodontics			
D4341	Deep cleaning for 4 or more teeth in a quadrant	1 of (D4341-D4342) per quadrant every 2 plan years; only two quadrants allowed on same date of service.	**Y**
D4342	Deep cleaning for 1-3 teeth in a quadrant	1 of (D4341-D4342) per quadrant every 2 plan years; only two quadrants allowed on same date of service.	**Y**
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	1 (D4346) every 2 plan years, not allowed within six months of D1110, D4341, D4342, D4355, or D4910.	**N**
D4355	Full mouth debridement to enable comprehensive oral evaluation and diagnosis on subsequent visit	1 of (D4355) every 2 plan years not allowed same DOS as D0180 or within 6 months of D0120, D0150 or D0180.	**N**
D4910	Periodontal maintenance	2 of (D4910) every plan year; not within 90 days of D1110.	**N**
Oral Surgery			
D7140	Extraction, erupted tooth or exposed root	1 of D7140 per tooth per lifetime.	**N**
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	1 of D7210 per tooth per lifetime.	**Y**

Code	General Service Description	Periodicity	Prior Auth
D7250	Removal of residual tooth roots (cutting procedure)	1 of (D7140, D7210) per tooth per lifetime; D7250 requires evidence of previous failed extraction with retained root and not by same provider or group.	**Y**
Adjunctive General Services			
D9110	Palliative (emergency) treatment, minor procedure	1 of (D9110) per plan year.	**N**
D9222	Deep sedation/general anesthesia, first 15 minute increment	1 of (D9222, D9230, D9239, D9248) per date of service.	**Y**
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	7 of (D9223, D9243) per date of service.	**Y**
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	1 of (D9222, D9230, D9239, D9248) per date of service.	**Y**
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	7 of (D9223, D9243) per date of service.	**Y**
D9310	Consultation, other than requesting dentist	2 of (D0140, D0160, D9310) every plan year.	**N**
D9942	Repair and/or Reline of Occlusal Guard	1 of (D9942) every 2 plan years, not within six months of appliance delivery.	**N**
D9944	Occlusal guard, hard appliance, full arch	1 of (D9944-D9946) every 5 plan years.	**N**
D9945	Occlusal guard, soft appliance, full arch	1 of (D9944-D9946) every 5 plan years.	**N**
D9946	Occlusal guard, hard appliance, partial arch	1 of (D9944-D9946) every 5 plan years.	**N**
D9995	Teledentistry - synchronous; real-time encounter	1 of (D9995-D9996) per date of service.	**N**

Code	General Service Description	Periodicity	Prior Auth
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	1 of (D9995-D9996) per date of service.	**N**

Limitations:

- Optional treatment: If you select a more expensive service than is customarily provided, an alternate benefit allowance may be made for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost.
    - When posterior teeth are missing in both quadrants of the same arch, a benefit request for one or more posterior fixed bridges in that arch will be limited to the benefit of a conventional tooth and soft tissue-based partial denture.

Exclusions:

- Services or supplies for correction of congenital or developmental malformations.
- Cosmetic dentistry services or surgery for aesthetic purposes (including the treatment of congenital or developmental malformations, bleaching of teeth and grafts to improve aesthetics).
- Charges for hospitalization, laboratory tests, and histopathological examinations.
- Charges for failure to keep a scheduled appointment with the Dentist.
- Services or supplies for which no valid dental need can be demonstrated.
- Services or supplies that do not meet accepted standards of dental practice.
- Services or supplies that are investigational or experimental in nature, including services required to treat complications from investigational or experimental procedures.
- Services or supplies covered under a hospital, surgical/medical (including Medicare Advantage), or prescription drug program.
- Appliances, restorations, or services for the diagnosis or treatment of disturbances or dysfunction of the temporomandibular joint (TMJ).
- Appliances, surgical procedures, and restorations (amalgam or composite resin fillings, crowns, bridges, inlays, or onlays) for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting.
- Services or supplies not listed in the above table.

Treatment Completion Date

Treatment completion date is defined as the date that treatment is complete and may be billable. Treatment is complete on dates of delivery for removable complete and partial dentures, final cementation for crowns and bridges, and final fill for root canals.

Prior Authorization

Prior Authorization is required prior to treatment for certain codes and addresses issues of eligibility and available benefits at the time of request. This is not a guarantee of payment. Approval of payment is based upon the member's eligibility on the date of service, dental record documentation, and any policy limitations and remaining available benefits on the date of service.

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