

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 package 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
WI	H8189001000	Wellcare Dual Access (HMO D-SNP)
WI	H8189007000	Wellcare All Dual Assure (HMO D-SNP)

Covered Dental Benefits: Our plan contracts with Delta Dental of Wisconsin, Inc., to administer the covered dental benefits described below. **If a dental procedure is not on the list below, it is not covered by your plan.** Refer to your 2024 *Evidence of Coverage* for any applicable cost sharing and benefit maximum. Please note, Pre-Service Organization Determinations (PSOD) expire at the end of the benefit year. Once a new benefit year begins, it is recommended another request for a PSOD is submitted to determine whether the service is covered under the current benefit plan.

IMPORTANT: If you receive services from a dentist that DOES NOT participate in this dental plan’s network, YOU WILL BE RESPONSIBLE for the full cost of those services and no payment will be made by us.

*Please note, certain procedures may require routine review or diagnostic information such as radiographs or patient treatment records for claims processing and final payment determinations. If further clarification regarding your coverage and benefits is needed, please ask your dentist for a pre-service organization determination.

Dental 2024 Schedule of Benefits

Code	Description	Benefit Limitations
D0100-D0999 Diagnostic		
D0120	periodic oral evaluation – established patient	Twice per calendar year
D0140	limited oral evaluation – problem focused	As needed for diagnosis of emergency condition
D0150	comprehensive oral evaluation – new or established patient	Once per 36 months
D0160	detailed and extensive oral evaluation - problem focused, by report	Once per 36 months
D0180	comprehensive periodontal evaluation - new or established patient	Once per calendar year
D0190	screening of a patient	Once per calendar year
D0210	intra-oral - complete series	Once per 36 months
D0220*, D0230*, D0240*, D0250*	Intraoral/extra-oral - periapical image, occlusal image	Covered service
D0270, D0272, D0273, D0274, D0277	bitewing x-rays	Once per calendar year
D0330	panoramic image	Once per 36 months
D0419	assessment of salivary flow by measurement	Once per 36 months
D0460	pulp vitality tests	Payable per visit not per tooth for the diagnosis of emergency conditions

Code	Description	Benefit Limitations
D0486*	accession of transepithelial cytologic sample, microscopic examination, preparation, and transmission of written report	Covered service; Paid in conjunction with brush biopsy (D7288)
D0999	unspecified diagnostic procedure, by report	Benefit determined by consultant review
D1000-D1999 Preventive		
D1110	prophylaxis - adult	Twice per calendar year
D1206, D1208	topical application of fluoride	Once per calendar year
D1999*	unspecified preventive procedure, by report	Benefit determined by consultant review
D2000-D2999 Restorative		
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390	amalgam and resin-based composite	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface
D2391, D2392, D2393, D2394	resin-based composite - posterior	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination
D2710*, D2712*, D2720*, D2721*, D2722*, D2740*, D2750*, D2751*, D2752*, D2753*, D2783*	crown - resin-based composite or porcelain/ceramic	Once per tooth per 60 months
D2790*, D2791*, D2792*, D2794*	crown - full cast	Once per tooth per 60 months
D2794*	crown - titanium and titanium alloys	Once per tooth per 60 months
D2910*	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	Covered service
D2915*	re-cement or re-bond indirectly fabricated or prefabricated post and core	Covered service
D2920*	re-cement or re-bond crown	Covered service
D2921*	reattachment of tooth fragment, incisal edge or cusp	Covered service

Code	Description	Benefit Limitations
D2928*, D2929*, D2930*, D2931*, D2932*, D2933*, D2934*	prefabricated crown	Covered service
D2940	protective restoration	Once per tooth per lifetime and considered to be part of the fee when done in conjunction with a definitive restoration, indirect pulp cap or endodontic treatment (including pulpotomy)
D2941	interim therapeutic restoration - primary dentition	Once per primary tooth
D2950*	core buildup, including any pins when required	Once per tooth per 60 months
D2951*	pin retention - per tooth, in addition to restoration	Once per tooth per lifetime
D2952*, D2954*	post and core in addition to crown	Once per tooth per 60 months
D2955*	post removal	Covered service
D2971*	additional procedures to construct new crown under existing partial denture framework	Covered service
D2980*, D2981*, D2982*, D2983*	repair necessitated by restorative material failure	Covered service
D2999*	unspecified restorative procedure, by report	Benefit determined by consultant review
D3000-D3999 Endodontics		
D3220*	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	Covered service
D3221*	pulpal debridement, primary or permanent teeth	Covered service
D3222*	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	Once per tooth per lifetime; additional benefit will require review
D3230*, D3240*	pulpal therapy (resorbable filling) - any tooth (excluding final restoration)	Covered Service
D3310*, D3320*, D3330*	endodontic therapy, (excluding final restoration)	Covered Service
D3332*	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Covered Service

Code	Description	Benefit Limitations
D3333*	internal root repair of perforation defects	Covered Service
D3346*, D3347*, D3348*	retreatment of previous root canal therapy	Covered Service
D3351*, D3352*, D3353*	apexification/recalcification (apical closure/calcific repair of perforations, root resorption, root canal, pulp space, disinfection etc.)	Covered Service
D3410*, D3421*, D3425*, D3426*	apicoectomy	Covered Service
D3427*	peri-radicular surgery without apicoectomy	Covered Service
D3430*	retrograde filling - per root	Covered Service
D3450*	root amputation - per root	Covered Service
D3920*	hemisection (including any root removal), not including root canal therapy	Covered Service
D3999*	unspecified endodontic procedure, by report	Benefit determined by consultant review
D4000-D4999 Periodontics		
D4210*, D4211*	gingivectomy or gingivoplasty	Once per 36 months
D4240*, D4241*	gingival flap procedure, including root planing	Once per 36 months
D4245*	apically positioned flap	Covered service
D4249*	clinical crown lengthening - hard tissue	Once per tooth per 24 months
D4260*, D4261*	osseous surgery (including elevation of a full thickness flap and closure)	Once per 36 months
D4263*, D4264*	bone replacement graft - retained natural tooth	Once per 36 months
D4265*	biologic materials to aid in soft and osseous tissue regeneration	Once per 36 months
D4266*, D4267*	guided tissue regeneration	Once per 36 months
D4268*	surgical revision procedure, per tooth	Once per 36 months
D4270*	pedicle soft tissue graft procedure	Once per 36 months
D4273*, D4277*, D4278*	free soft tissue graft procedure (including recipient and donor site surgery)	Once per 36 months
D4274*	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Covered service

Code	Description	Benefit Limitations
D4275*	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	Once per 36 months
D4276*, D4283*, D4285*	connective tissue graft (including recipient site and donor material)	Once per 36 months
D4341*, D4342	periodontal scaling and root planing	Once per quadrant per 24 months. No more than 2 quadrants of scaling and root planing on the same date of service
D4346*	scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	Included in the cleaning frequency of twice per calendar year
D4355*	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	Once per lifetime
D4910*	periodontal maintenance	Included in the cleaning frequency of twice per calendar year
D4999*	unspecified periodontal procedure, by report	Benefit determined by consultant review
D5000-D5899 Prosthodontics (Removable)		
D5110*, D5120*, D5130*, D5140*	complete/immediate denture	One complete denture (any type) per arch per 60 months
D5211*, D5212*, D5213*, D5214*	partial denture - resin base (including retentive/clasping materials, rests and teeth)	One partial denture (any type) per arch per 60 months
D5221*, D5222*, D5223*, D5224*	immediate partial denture - resin base (including retentive/clasping materials, rests and teeth)	One partial denture (any type) per arch per 60 months
D5225*, D5226*	partial denture - flexible base (including retentive/clasping materials, rests and teeth)	One partial denture (any type) per arch per 60 months
D5282*, D5283*, D5284*, D5286*	removable unilateral partial denture (including retentive/clasping materials, rests, and teeth)	One partial denture (any type) per arch per 60 months
D5410*, D5411*, D5421*, D5422*	adjust complete/partial denture	Covered service
D5511*, D5512*, D5611*, D5612*, D5621*, D5622*, D5630*	repair broken complete or partial denture	Covered service

Code	Description	Benefit Limitations
D5520*	replace missing or broken teeth - complete denture (each tooth)	Covered service
D5640*	replace broken teeth - per tooth	Covered service
D5650*	add tooth to existing partial denture	Covered service
D5660*	add clasp to existing partial denture - per tooth	Covered service
D5670*, D5671*	replace all teeth and acrylic on cast metal framework	Covered service
D5710, D5711, D5720, D5721	rebase complete or partial denture	Once per 36 months
D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761	reline complete or partial denture	Once per 36 months
D5810*, D5811*	interim complete denture	Covered service
D5820, D5821	interim partial denture	Payable for the replacement of permanent anterior teeth during the healing period
D5850, D5851	tissue conditioning	Twice per 36 months
D5862	precision attachment, by report	Covered service
D5899*	unspecified removable prosthodontic procedure, by report	Benefit determined by consultant review
D5931*	obturator prosthesis, surgical	Subject to review
D5999*	unspecified maxillofacial prosthesis, by report	Benefit determined by consultant review
D6000-D6199 Implant Services		
D6010*	surgical placement of implant body: endosteal implant	Two implants (any type) per 12 months. Once per tooth per 60 months
D6013*	surgical placement of mini implant	Two implants (any type) per 12 months. Once per tooth per 60 months
D6056*	prefabricated abutment - includes modification and placement	Two abutments (any type) per 12 months. Once per tooth per 60 months
D6057*	custom abutment - includes placement	Two abutments (any type) per 12 months. Once per tooth per 60 months
D6058*, D6059*, D6060*, D6061*, D6062*, D6063*, D6064*	abutment supported crown, any material	Two single unit implant crowns (any typed) per 12 months. Once per tooth per 60 months

Code	Description	Benefit Limitations
D6065*, D6066*, D6067*, D6082*, D6083*, D6084*, D6086*, D6087*, D6088*	implant supported crown, any material	Two single unit implant crowns (any type) per 12 months. Once per tooth per 60 months
D6080*	implant maintenance procedures - when prostheses are removed and reinserted, including cleansing of prostheses and abutments	Once per 12 months
D6081*	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	Once per 24 months
D6082*, D6083*, D6084*	implant supported crown - porcelain	Two single unit implant crowns (any type) per 12 months. Once per tooth per 60 months
D6086*, D6087*, D6088*	implant supported crown - metal	Two single unit implant crowns (any type) per 12 months. Once per tooth per 60 months
D6090*	repair implant supported prosthesis, by report	Covered service
D6092*, D6093*	recement implant/abutment supported crown or fixed partial denture	Covered service
D6094*, D6097*	abutment supported crown	Two single unit implant crowns (any type) per 12 months. Once per tooth per 60 months
D6095*	repair implant abutment, by report	Covered service
D6096*	Remove broken implant retaining screw	Once per tooth per 60 months
D6100*	implant removal, by report	Once per tooth per lifetime
D6199*	unspecified implant procedure, by report	Benefit determined by consultant review
D6200-D6299 Prosthodontics (Fixed)		
D6210*, D6211*, D6212*, D6214*	pontic	One pontic (any type) per tooth per 60 months. Pontics are not covered when part of implant restorations.
D6240*, D6241*, D6242*, D6243*	pontic - porcelain fused	One pontic (any type) per tooth per 60 months. Pontics are not covered when part of implant restorations.

Code	Description	Benefit Limitations
D6250*, D6251*, D6252*	pontic - resin	One pontic (any type) per tooth per 60 months. Pontics are not covered when part of implant restorations.
D6545*	retainer - cast metal for resin bonded fixed prosthesis	One retainer crown (any type) per tooth per 60 months
D6720*, D6721*, D6722*	retainer crown - resin with high noble metal	One retainer crown (any type) per tooth per 60 months
D6750*, D6751*, D6752*, D6753*	retainer crown - porcelain fused to high noble metal	One retainer crown (any type) per tooth per 60 months
D6790*, D6791*, D6792*, D6794*	retainer crown - full cast	One retainer crown (any type) per tooth per 60 months
D6930*	re-cement or re-bond fixed partial denture	Covered service
D6980*	fixed partial denture repair, necessitated by restorative material failure	Covered service
D6999*	unspecified fixed prosthodontic procedure, by report	Benefit determined by consultant review
D7000-D7999 Oral and Maxillofacial Surgery		
D7111*	extraction, coronal remnants - primary tooth	Once per tooth per lifetime
D7140*	extraction, erupted tooth or exposed root (elevation and or forceps removal)	Once per tooth per lifetime
D7210*	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated	Once per tooth per lifetime
D7220*, D7230*, D7240*	removal of impacted tooth	Once per tooth per lifetime
D7241*	removal of impacted tooth - completely bony, with unusual surgical complications	Once per tooth per lifetime
D7250*	removal of residual tooth roots (cutting procedure)	Once per tooth per lifetime
D7251*	coronectomy - intentional partial tooth removal	Once per tooth per lifetime

Code	Description	Benefit Limitations
D7270*	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Covered service
D7280*	exposure of an unerupted tooth	Once per tooth per lifetime
D7282*	mobilization of erupted or malpositioned tooth to aid eruption	Once per tooth per lifetime
D7283*	placement of device to facilitate eruption of impacted tooth	Covered service
D7286*	biopsy of oral tissue - soft	Subject to services it is performed in conjunction with. Predetermination is strongly recommended.
D7288*	brush biopsy - transepithelial sample collection	Covered service
D7290*	surgical repositioning of teeth	Covered service
D7291*	transeptal fiberotomy/supra crestal fiberotomy, by report	Covered service
D7310*, D7311*	alveoplasty in conjunction with extractions - per quadrant	Covered service
D7320*, D7321*	alveoplasty not in conjunction with extractions - per quadrant	Covered service
D7450*	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	Covered service
D7451*	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Covered service
D7510*	incision and drainage of abscess - intraoral soft tissue	Covered service
D7511*	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	Covered service
D7997*	appliance removal (not by dentist who placed appliance), includes removal of archbar	Covered service
D7999*	unspecified oral surgery procedure, by report	Benefit determined by consultant review
D9000-D9999 Adjunctive General Services		
D9110	palliative (emergency) treatment of dental pain - minor procedure	As needed for diagnosis of emergency condition
D9120*	fixed partial denture sectioning	Covered service
D9222, D9223	deep sedation/general anesthesia	Paid in conjunction with qualifying services

Code	Description	Benefit Limitations
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	Covered service
D9239, D9243	intravenous moderate (conscious) sedation/analgesia	Paid in conjunction with qualifying services
D9310*	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Covered service
D9410* D9420*	house/extended care facility call hospital or ambulatory surgical center call	Requires consultant review
D9440	office visit - after regularly scheduled hours	As needed for diagnosis of emergency condition
D9930*	treatment of complications (post-surgical) - unusual circumstances, by report	Covered service
D9944, D9946	occlusal guard - hard appliance	One hard occlusal guard (any type) per 60 months
D9951	occlusal adjustment - limited	Payable three times in a 60-month period
D9952	occlusal adjustment - complete	Once per 60 months
D9999*	unspecified adjunctive procedure, by report	Benefit determined by consultant review

Exclusions:

- Services or supplies for correction of congenital or developmental malformations.
- Cosmetic dentistry services or surgery for aesthetic reasons.
- Charges for hospitalization, laboratory tests, and histopathological examinations and miscellaneous tests.
- 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.
- Lost, missing, or stolen appliances of any type.
- Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
- Services associated with overdentures.

- Appliances, restorations, or services for the diagnosis or treatment of disturbances or dysfunction of the temporomandibular joint (TMJ).
- Appliances, surgical procedures, and restorations 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 schedule of benefits.

Treatment Completion Date

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;
- For root canals and periodontal treatment, on the date the final procedure that completes treatment.

Pre-Service Organization Determination

Pre-service organization determination is a determination that is made prior to receiving dental services based on your benefits and coverage. This decision will determine whether a dental service will be covered and will provide information on how much you may have to pay for this service. This is a request submitted by you or your dentist.

