

Dental Quick Reference Guide

HealthTeam Advantage Diabetes & Heart Care
(HMO C-SNP) H2624-001



Dental Quick Reference Guide

Dental insurance can be confusing, and this guide is designed to help.

HealthTeam Advantage partners with Dominion Dental Services, Inc., on dental benefits. As a member of the Diabetes & Heart Care Plan, you can choose dentists from Dominion Dental's North Carolina dental network. This dental plan covers in-network dental coverage only. **There are no out-of-network dental benefits under this plan.**



HealthTeam Advantage Diabetes & Heart Care (HMO C-SNP) Plan includes both Diagnostic/Preventive and Comprehensive dental services.

- ◆ **Diagnostic/Preventive** services include services such as cleanings, routine dental exams, and dental X-rays.
- ◆ **Comprehensive** services include services such as fillings, dentures, and crowns.



We're Here for You



Your Healthcare Concierge is here to help you make the most of your benefits. Just call or email for fast, friendly assistance.

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8 a.m.-8 p.m.

Oct. 1-March 31, 7 Days a Week
April 1-Sept. 30, Monday-Friday

About This Guide

This Quick Reference Guide is designed to help you understand your dental coverage. It includes a brief description of the benefits, frequency of services, and amounts you are responsible for paying for covered dental services under the plan.

Every dental procedure has an American Dental Association (ADA) procedure code. All services in this guide are listed by ADA procedure code. It is generally a good idea to have the procedure code when you are looking up coverage, as the procedures have very specific descriptions. Ask your provider for the procedure code for any services you are considering.

Any services not listed in this guide are **NOT** covered.

Covered dental services are subject to Dominion National Processing Policies, limitations, and exclusions. Dental lab fees are not covered, so you may be responsible for the costs of any dental lab services you need. Speak to your dental provider for more information.

Remember, if you receive services from a dentist that **does not** participate in Dominion Dental Services, Inc., Medicare Advantage Network, **you will be responsible for all costs.**



Non-Medicare covered Supplemental Dental Benefits

Coverage Description

Your Supplemental Dental Benefit under this plan is offered by HealthTeam Advantage in partnership with Dominion Dental Services, Inc. Please note that Original Medicare does not cover most dental services. Below is an overview of the services covered under the plan, along with how often they are covered and the amount you are responsible for. Any dental services not listed are NOT covered. This dental plan only provides in-network dental care. **There are no out-of-network dental benefits under this plan. You must use a Dominion Dental participating dental provider.**

Important: If you see a dentist who is not part of the Dominion Dental Medicare Advantage Network, you will have to pay the full costs for the services provided.

Benefit Year: January 1 through December 31, 2026

Deductible: \$100 (applies to all Comprehensive dental services)

Annual Benefit Maximum:

Diabetes and Heart Care Plan: \$1,500

per person total per Benefit Year
for in-network Comprehensive dental services

Office Visit Copay: \$0 copay per office visit

Dental lab fees are not covered, so you may be responsible for the costs of any dental lab services you need. Speak to your dental provider for more information.

Covered dental services are subject to Dominion National Processing Policies, limitations, and exclusions. Alternate benefits and frequency and visit limits apply to Diagnostic and Preventive and Comprehensive dental services.

Non-Medicare covered Supplemental Dental Benefits

Deductible and Coinsurance by Dental Service Category

Dental Service Category	Subject to Deductible (\$100 Deductible)	What you pay (In-Network)	What you pay (Out-of-Network)
Diagnostic and Preventive Dental Services (Routine) <ul style="list-style-type: none"> - Prophylaxis (cleanings) - Radiographs/Diagnostic Imaging (X-rays) - Oral evaluations 	No	0% coinsurance	No Benefit
Comprehensive Dental Services <ul style="list-style-type: none"> - Amalgam and composite fillings - Periodontal maintenance - Simple extractions 	Yes	20% coinsurance after the annual deductible is met	No Benefit
Comprehensive Dental Services <ul style="list-style-type: none"> - Restorative services (inlays/onlays) - Crowns - Endodontics (root canals) - Periodontics (deep cleanings) - Prosthodontics (fixed and removable) - Oral and maxillofacial surgery - Adjunctive general services 	Yes	50% coinsurance after the annual deductible is met	No Benefit

NOTE: Refer to the dental code section for specific coverage details for covered dental services by procedure code.

General Information

It may be necessary for dental codes listed to be changed to comply with State, Federal, and American Dental Association (ADA) regulations. The ADA codes are subject to annual updates which may not be reflected in the list provided.

- ◆ After the annual maximum is exhausted, any remaining charges are your responsibility.
- ◆ Any amount unused at the end of the year will expire.
- ◆ In-network dental providers are paid based on contracted rates for each covered dental service. Any fees associated with non-covered services are your responsibility.
- ◆ The plan does **not** provide coverage for services obtained out-of-network. If you choose to see an out-of-network dentist, you will be billed by that provider for the full cost of the service(s) and the Plan will pay nothing.

Note: *Diagnostic/Preventive and Comprehensive dental deductibles, copays, and cost shares do not apply to your HealthTeam Advantage Maximum Out-of-Pocket (MOOP).*



Clinical Review

Procedures marked with a “+” symbol in the dental code chart may be subject to clinical review. We may review requests for payment to ensure that the care and services you received were necessary and provided in accordance with generally accepted dental practices. Clinical review is performed when we receive a claim for payment of services that have already been provided. You can obtain a copy of Dominion Dental’s Clinical Review Guidelines on our website or by calling Member Services.

Optional Pre-Treatment Estimate

If your dentist has recommended services and you are concerned about coverage or costs, your dentist can ask for a pre-treatment estimate. We will review your dentist’s proposed treatment and send your dentist information explaining what services will be covered and your estimated out-of-pocket costs for these services. A pre-treatment estimate can help you better understand what will be covered and the amount you will need to pay.



Alternate Dental Benefit

If you receive a dental service for which 1) the plan determines that a less expensive, clinically appropriate alternative procedure, service, or course of treatment can be performed in place of the proposed treatment to correct the dental condition is available; 2) the alternate treatment will produce a professionally satisfactory result; then the maximum the plan will allow will be the charge for the less expensive treatment (alternate benefit procedure) rather than the service actually performed.

You can still choose the treatment your dentist recommends. However, payment is limited to the allowed amount of the lower-cost dental procedure (alternate benefit) as determined by Dominion Dental Services. Alternate benefit determinations follow Dominion Dental Services' clinical review guidelines and plan benefit rules. You are responsible for any difference between the provider's charge and the plan's payment.

Note: Application of alternate benefits does not constitute a denial of coverage.

Expenses Incurred

An Eligible Expense is considered incurred on the following dates:

a) Dentures - on the date the final impression is taken; b) Fixed bridges, crowns, inlays, and onlays - on the date the teeth are initially prepared; c) Root canal therapy - on the date the pulp chamber is opened; d) Periodontal surgery - on the date surgery is performed; and e) All Other Services - on the date the service is performed.

Coverage Exclusions

HealthTeam Advantage Diabetes & Heart Care plan does not cover the following dental services and procedures:

- ◆ If a code is not listed in this dental guide, it is not a covered dental service.
- ◆ Services which are covered under Medicare, workers' compensation, or employer's liability laws.
- ◆ Services that are not necessary for the patient's dental health.
- ◆ Reconstructive, plastic, cosmetic, elective, or aesthetic dentistry.
- ◆ Oral surgery requiring the setting of fractures and dislocations.
- ◆ Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism, or development malformations where such services should not be performed in a dental office.
- ◆ Dispensing of drugs.
- ◆ Hospitalization for any dental procedure.
- ◆ Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
- ◆ Implant removal or the replacement of dentures, bridges, inlays, onlays, or crowns that can be repaired or restored to normal function.
- ◆ Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems, and/or occlusal disharmony.
- ◆ Elective surgery, including but not limited to the extraction of non-pathologic, asymptomatic impacted teeth.
- ◆ Implant coverage is limited to abutment supported porcelain and cast metal crowns and implant supported crowns. The surgical placement of implant body is not a covered service.
- ◆ Replacement of lost, stolen, or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.
- ◆ Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
- ◆ Procedures that, in the opinion of the plan, are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the member's condition.
- ◆ Treatment of cleft palate, malignancies, or neoplasms.
- ◆ Orthodontia services are not covered.

Filing a Claim

When you have covered dental services performed by an in-network participating dentist, the dentist will submit the claim on your behalf. Dentists may ask you to sign an informed consent document detailing the risks, benefits, costs, and alternatives to all recommended treatments. You may obtain specific plan coverage details related to your proposed treatment plan by asking the dentist to obtain a pre-treatment estimate from Dominion Dental Services, Inc. If the provider has questions about how to obtain this information, they can contact Dominion Dental Services, Inc., using the telephone number on the back of your Member ID card.

Dental services are subject to Dominion Dental Services' standard claims review procedures, which could include dental history, to approve coverage. Dental benefits under this plan may not cover all American Dental Association procedure codes.



2026

Diabetes & Heart Care (HMO C-SNP)



+ Procedures marked with a “+” in the code chart below may be subject to clinical review. We may review requests for payment to ensure that care and services were necessary and provided in accordance with generally accepted dental practice. Clinical review is performed when we receive a claim for payment of services that have already been provided. To view or print Dominion National’s 2026 Clinical Review Guidelines, visit the HealthTeam Advantage website at www.htanc.com/members/member-resources.

DIAGNOSTIC AND PREVENTIVE DENTAL SERVICES (ROUTINE)

American Dental Association (ADA) Code	Dental Procedure Description (Easy to interpret description of the dental procedure code)	Frequency (How often your plan will pay for the procedure)	In-Network You Pay	Out-of-Network Not Covered
Preventive				
Dental Prophylaxis & Office Visits				
D1110	Prophylaxis, adult	2 per calendar year	0%	N/A
D9311	Consultation with a medical health care professional	Covered service	0%	N/A
D9995	Teledentistry - synchronous; real-time encounter	Must be submitted with a covered procedure	0%	N/A
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	Must be submitted with a covered procedure	0%	N/A
Diagnostic				
Clinical Oral Evaluations				
D0120	Periodic Oral Evaluation - established patient	2 per calendar year	0%	N/A
D0140	Limited Oral Evaluation - problem focused	1 every 12 months	0%	N/A
D0150	Comprehensive Oral Evaluation - new or established patient	1 per 36 months	0%	N/A
D0160	Detailed and Extensive Oral Evaluation - problem focused, by report	1 every lifetime	0%	N/A
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	1 every lifetime	0%	N/A
D0171	Re-evaluation - post-operative office visit	Covered service	0%	N/A
D0180	Comprehensive periodontal evaluation - new or established patient	1 every 36 months	0%	N/A

American Dental Association (ADA) Code	Dental Procedure Description (Easy to interpret description of the dental procedure code)	Frequency (How often your plan will pay for the procedure)	In-Network You Pay	Out-of-Network Not Covered
Radiographs/Diagnostic Imaging (X-rays)				
D0210	Intraoral - comprehensive series of radiographic images	1 every 60 months	0%	N/A
D0220	Intraoral - periapical first radiographic image	Covered service	0%	N/A
D0230	Intraoral - periapical each additional radiographic image	Covered service	0%	N/A
D0240	Intraoral - occlusal radiographic image	Covered service	0%	N/A
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	Covered service	0%	N/A
D0270	Bitewing - single radiographic image	2 per calendar year	0%	N/A
D0272	Bitewings - two radiographic images	2 per calendar year	0%	N/A
D0273	Bitewings - three radiographic images	2 per calendar year	0%	N/A
D0274	Bitewings - four radiographic images	2 per calendar year	0%	N/A
D0277	Vertical bitewings - 7 to 8 radiographic images	2 per calendar year	0%	N/A
D0322	Tomographic survey	Covered service	0%	N/A
D0330	Panoramic radiographic image	1 every 60 months	0%	N/A
D0470	Diagnostic casts	1 every 60 months	0%	N/A



American Dental Association (ADA) Code	Dental Procedure Description (Easy to interpret description of the dental procedure code)	Frequency (How often your plan will pay for the procedure)	In-Network You Pay	Out-of-Network Not Covered
COMPREHENSIVE DENTAL SERVICES				
Restorative Services				
Amalgam and Composite Restorations				
D2140	Amalgam Filling - one surface, primary or permanent	1 per 24 months	20%	N/A
D2150	Amalgam Filling - two surfaces, primary or permanent	1 per 24 months	20%	N/A
D2160	Amalgam Filling - three surfaces, primary or permanent	1 per 24 months	20%	N/A
D2161	Amalgam Filling - four surfaces, primary or permanent	1 per 24 months	20%	N/A
D2330	Resin-Based Composite, one surface, anterior	1 per 24 months	20%	N/A
D2331	Resin-Based Composite, two surfaces, anterior	1 per 24 months	20%	N/A
D2332	Resin-Based Composite, three surfaces, anterior	1 per 24 months	20%	N/A
D2335	Resin-Based Composite, four or more surfaces or involving incisal angle (anterior)	1 per 24 months	20%	N/A
D2391	Resin-Based Composite, one surface, posterior	1 per 24 months	20%	N/A
D2392	Resin-Based Composite, two surfaces, posterior	1 per 24 months	20%	N/A
D2393	Resin-Based Composite, three surfaces, posterior	1 per 24 months	20%	N/A
D2394	Resin-Based Composite, four surfaces, posterior	1 per 24 months	20%	N/A

American Dental Association (ADA) Code	Dental Procedure Description (Easy to interpret description of the dental procedure code)	Frequency (How often your plan will pay for the procedure)	In-Network You Pay	Out-of-Network Not Covered
Restorative Services (continued)				
Inlays/Onlays				
D2510+	Inlay - metallic - one surface	Once every 7 years	50%	N/A
D2520+	Inlay - metallic - two surfaces	Once every 7 years	50%	N/A
D2530+	Inlay - metallic - three or more surfaces	Once every 7 years	50%	N/A
D2542+	Onlay - metallic - two surfaces	Once every 7 years	50%	N/A
D2543+	Onlay - metallic - three surfaces	Once every 7 years	50%	N/A
D2544+	Onlay - metallic - four or more surfaces	Once every 7 years	50%	N/A
D2610+	Inlay - porcelain/ceramic - one surface Alternate benefit of D2510	Once every 7 years	50%	N/A
D2620+	Inlay - porcelain/ceramic - two surfaces Alternate benefit of D2520	Once every 7 years	50%	N/A
D2630+	Inlay - porcelain/ceramic - three or more surfaces Alternate benefit of D2530	Once every 7 years	50%	N/A
D2642+	Onlay - porcelain/ceramic - two surfaces	Once every 7 years	50%	N/A
D2643+	Onlay - porcelain/ceramic - three surfaces	Once every 7 years	50%	N/A
D2644+	Onlay - porcelain/ceramic - four or more surfaces Alternate benefit of D2544	Once every 7 years	50%	N/A
D2650+	Inlay - resin-based composite - one surface Alternate benefit of D2510	Once every 7 years	50%	N/A
D2651+	Inlay - resin-based composite - two surfaces Alternate benefit of D2520	Once every 7 years	50%	N/A
D2652+	Inlay - resin-based composite - three or more surfaces Alternate benefit of D2530	Once every 7 years	50%	N/A
D2662+	Onlay - resin-based composite - two surfaces	Once every 7 years	50%	N/A
D2663+	Onlay - resin-based composite - three surfaces	Once every 7 years	50%	N/A
D2664+	Onlay - resin-based composite - four or more surfaces Alternate benefit of D2544	Once every 7 years	50%	N/A

American Dental Association (ADA) Code	Dental Procedure Description (Easy to interpret description of the dental procedure code)	Frequency (How often your plan will pay for the procedure)	In-Network You Pay	Out-of-Network Not Covered
Crowns				
D2710+	Crown - resin-based composite (indirect)	Once every 7 years	50%	N/A
D2740+	Crown - porcelain/ceramic Alternate benefit of D2751	Once every 7 years	50%	N/A
D2750+	Crown - porcelain fused to high noble metal Alternate benefit of D2751	Once every 7 years	50%	N/A
D2751+	Crown - porcelain fused to predominantly base metal	Once every 7 years	50%	N/A
D2752+	Crown - porcelain fused to noble metal Alternate benefit of D2751	Once every 7 years	50%	N/A
D2780+	Crown - 3/4 cast high noble metal Alternate benefit of D2781	Once every 7 years	50%	N/A
D2781+	Crown - 3/4 cast predominantly base metal	Once every 7 years	50%	N/A
D2782+	Crown - 3/4 cast noble metal Alternate benefit of D2781	Once every 7 years	50%	N/A
D2783+	Crown - 3/4 porcelain/ceramic Alternate benefit of D2781	Once every 7 years	50%	N/A
D2790+	Crown - full cast high noble metal Alternate benefit of D2791	Once every 7 years	50%	N/A
D2791+	Crown - full cast predominantly base metal	Once every 7 years	50%	N/A
D2792+	Crown - full cast noble metal Alternate benefit of D2791	Once every 7 years	50%	N/A
D2799	Interim crown - further treatment or completion of diagnosis necessary prior to final impression	Once every 7 years	50%	N/A



American Dental Association (ADA) Code	Dental Procedure Description (Easy to interpret description of the dental procedure code)	Frequency (How often your plan will pay for the procedure)	In-Network You Pay	Out-of-Network Not Covered
Other Restorative Services				
D2910	Re-cement or re-bond inlay, onlay or partial coverage restoration	Once every 12 months	50%	N/A
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	Once every 12 months	50%	N/A
D2920	Re-cement or re-bond crown	Once every 12 months	50%	N/A
D2931	Prefabricated stainless steel crown - permanent tooth	Once every 7 years	50%	N/A
D2932	Prefabricated resin crown	Once every 7 years	50%	N/A
D2940	Protective Restoration	Covered service	50%	N/A
D2950+	Core buildup, including any pins when required	Once every 7 years	50%	N/A
D2951+	Pin retention - per tooth, in addition to restoration	Covered service	50%	N/A
D2952+	Post and core in addition to crown, indirectly fabricated	Once every 7 years	50%	N/A
D2953+	Each additional indirectly fabricated post - same tooth	Covered service	50%	N/A
D2954+	Prefabricated post and core in addition to crown	Once every 7 years	50%	N/A
D2955	Post removal	Covered service	50%	N/A
D2957+	Each additional prefabricated post - same tooth	Covered service	50%	N/A
D2971+	Additional procedures to customize a crown to fit under an existing partial denture framework	Covered service	50%	N/A
D2980	Crown repair necessitated by restorative material failure	Covered service	50%	N/A



American Dental Association (ADA) Code	Dental Procedure Description (Easy to interpret description of the dental procedure code)	Frequency (How often your plan will pay for the procedure)	In-Network You Pay	Out-of-Network Not Covered
Endodontic Services				
D3110+	Pulp cap - direct (excluding final restoration)	Covered service	50%	N/A
D3120+	Pulp cap - direct (excluding final restoration)	Covered service	50%	N/A
D3220+	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	Covered service	50%	N/A
D3221+	Pulpal debridement, primary or permanent teeth	Covered service	50%	N/A
D3310, D3320, D3330	Endodontic therapy (excluding final restoration)	One per tooth per lifetime	50%	N/A
D3331	Treatment of root canal obstruction; non-surgical access	Covered service	50%	N/A
D3332	Incomplete endodontic therapy; inoperable, unrestorable, or fractured tooth	Covered service	50%	N/A
D3333	Internal root repair of perforation defects	Covered service	50%	N/A
D3346, D3347, D3348	Retreatment of previous root canal therapy	One per tooth per lifetime	50%	N/A
D3410, D3421, D3425, D3426	Apicoectomy	Covered service	50%	N/A
D3430+	Retrograde filling - per root	One per tooth per lifetime	50%	N/A
D3450	Root amputation - per root	Covered service	50%	N/A
D3950+	Canal preparation and fitting of preformed dowel or post	Covered service	50%	N/A

American Dental Association (ADA) Code	Dental Procedure Description (Easy to interpret description of the dental procedure code)	Frequency (How often your plan will pay for the procedure)	In-Network You Pay	Out-of-Network Not Covered
Periodontal Services				
D4210+	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Covered service	50%	N/A
D4211+	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	Covered service	50%	N/A
D4212+	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Covered service	50%	N/A
D4240+	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Covered service	50%	N/A
D4241+	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Covered service	50%	N/A
D4249+	Clinical crown lengthening - hard tissue	Covered service	50%	N/A
D4260+	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	Covered service	50%	N/A
D4261+	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	Covered service	50%	N/A
D4263+	Bone replacement graft - retained natural tooth - first site in quadrant	Covered service	50%	N/A
D4264+	Bone replacement graft - retained natural tooth - each additional site in quadrant	Covered service	50%	N/A
D4266+	Guided tissue regeneration, natural teeth - resorbable barrier, per site	Once per lifetime	50%	N/A
D4267+	Guided tissue regeneration, natural teeth - non-resorbable barrier, per site	Once per lifetime	50%	N/A
D4270+	Pedicle soft tissue graft procedure	Once per lifetime	50%	N/A
D4273+	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Once per lifetime	50%	N/A

American Dental Association (ADA) Code	Dental Procedure Description (Easy to interpret description of the dental procedure code)	Frequency (How often your plan will pay for the procedure)	In-Network You Pay	Out-of-Network Not Covered
Periodontal Services (continued)				
D4277+	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	Once per lifetime	50%	N/A
D4341+	Periodontal scaling and root planing - four or more teeth per quadrant	1 per quadrant every 24 months	50%	N/A
D4342+	Periodontal scaling and root planing - one to three teeth per quadrant	1 per quadrant every 24 months	50%	N/A
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation Alternate benefit of D4355	1 per 24 months	50%	N/A
D4355	Full mouth debridement - to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	1 per lifetime	50%	N/A
D4910	Periodontal maintenance	2 per calendar year	20%	N/A
Prosthodontic Services (Removeable)				
Complete Dentures				
D5110	Complete denture - maxillary	1 set of full OR partial dentures every 7 years	50%	N/A
D5120	Complete denture - mandibular		50%	N/A
D5130	Immediate denture - maxillary		50%	N/A
D5140	Immediate denture - mandibular		50%	N/A
Partial Dentures				
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	1 set of full OR partial dentures every 7 years	50%	N/A
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)		50%	N/A
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)		50%	N/A



American Dental Association (ADA) Code	Dental Procedure Description (Easy to interpret description of the dental procedure code)	Frequency (How often your plan will pay for the procedure)	In-Network You Pay	Out-of-Network Not Covered
Partial Dentures <i>(continued)</i>				
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	1 set of full OR partial dentures every 7 years (continued from prior page)	50%	N/A
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)		50%	N/A
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)		50%	N/A
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) Alternate benefit of D5221		50%	N/A
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) Alternate benefit of D5222		50%	N/A
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)		50%	N/A
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)		50%	N/A
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary		50%	N/A
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular		50%	N/A

American Dental Association (ADA) Code	Dental Procedure Description (Easy to interpret description of the dental procedure code)	Frequency (How often your plan will pay for the procedure)	In-Network You Pay	Out-of-Network Not Covered
Adjustments/Repairs to Dentures				
D5410	Adjust complete denture - maxillary	2 per calendar year	50%	N/A
D5411	Adjust complete denture - mandibular	2 per calendar year	50%	N/A
D5421	Adjust partial denture - maxillary	2 per calendar year	50%	N/A
D5422	Adjust partial denture - mandibular	2 per calendar year	50%	N/A
D5511	Repair broken complete denture base, mandibular	1 per 24 months	50%	N/A
D5512	Repair broken complete denture base, maxillary	1 per 24 months	50%	N/A
D5520	Replace missing or broken teeth - complete denture (each tooth)	1 per 24 months	50%	N/A
D5611	Repair resin partial denture base, mandibular	1 per 24 months	50%	N/A
D5612	Repair resin partial denture base, maxillary	1 per 24 months	50%	N/A
D5621	Repair cast partial framework, mandibular	1 per 24 months	50%	N/A
D5622	Repair cast partial framework, maxillary	1 per 24 months	50%	N/A
D5630	Repair or replace broken retentive clasping materials - per tooth	1 per 24 months	50%	N/A
D5640	Replace broken teeth - per tooth	1 per 24 months	50%	N/A
D5650	Add tooth to existing partial denture	1 per 24 months	50%	N/A
D5660	Add clasp to existing partial denture - per tooth	1 per 24 months	50%	N/A
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	1 per 24 months	50%	N/A
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	1 per 24 months	50%	N/A



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Rebase/Reline Dentures				
D5710	Rebase complete maxillary denture	1 per 24 months	50%	N/A
D5711	Rebase complete mandibular denture	1 per 24 months	50%	N/A
D5720	Rebase maxillary partial denture	1 per 24 months	50%	N/A
D5721	Rebase mandibular partial denture	1 per 24 months	50%	N/A
D5730	Reline complete maxillary denture (direct)	1 per 24 months	50%	N/A
D5731	Reline complete mandibular denture (direct)	1 per 24 months	50%	N/A
D5740	Reline maxillary partial denture (direct)	1 per 24 months	50%	N/A
D5741	Reline mandibular partial denture (direct)	1 per 24 months	50%	N/A
D5750	Reline complete maxillary denture (indirect)	1 per 24 months	50%	N/A
D5751	Reline complete mandibular denture (indirect)	1 per 24 months	50%	N/A
D5760	Reline maxillary partial denture (indirect)	1 per 24 months	50%	N/A
D5761	Reline mandibular partial denture (indirect)	1 per 24 months	50%	N/A
Additional Denture Procedures				
D5810	Interim complete denture (maxillary)	1 set of full OR partial dentures every 7 years	50%	N/A
D5811	Interim complete denture (mandibular)	1 set of full OR partial dentures every 7 years	50%	N/A
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	1 set of full OR partial dentures every 7 years	50%	N/A
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	1 set of full OR partial dentures every 7 years	50%	N/A
D5850	Tissue conditioning, maxillary	Once every 7 years	50%	N/A
D5851	Tissue conditioning, mandibular	Once every 7 years	50%	N/A
D5863+	Overdenture - complete maxillary Alternate benefit of D5110	1 set of full OR partial dentures every 7 years	50%	N/A
D5864+	Overdenture - partial maxillary Alternate benefit of D5213	1 set of full OR partial dentures every 7 years	50%	N/A

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Additional Denture Procedures (continued)				
D5865+	Overdenture - complete mandibular Alternate benefit of D5120	1 set of full OR partial dentures every 7 years	50%	N/A
D5866+	Overdenture - partial mandibular Alternate benefit of D5214	1 set of full OR partial dentures every 7 years	50%	N/A
D5867	Replacement of replaceable part of semi-precision or precision attachment, per attachment	1 per 24 months	50%	N/A
D5875	Modification of removable prosthesis following implant surgery	Covered service	50%	N/A
Implant-related Services				
D6058+	Abutment supported porcelain/ceramic crown	Once per tooth every 7 years	50%	N/A
D6059+	Abutment supported porcelain fused to metal crown (high noble metal)	Once per tooth every 7 years	50%	N/A
D6060+	Abutment supported porcelain fused to metal crown (predominantly base metal)	Once per tooth every 7 years	50%	N/A
D6061+	Abutment supported porcelain fused to metal crown (noble metal)	Once per tooth every 7 years	50%	N/A
D6062+	Abutment supported cast metal crown (high noble metal)	Once per tooth every 7 years	50%	N/A
D6063+	Abutment supported cast metal crown (predominantly base metal)	Once per tooth every 7 years	50%	N/A
D6064+	Abutment supported cast metal crown (noble metal)	Once per tooth every 7 years	50%	N/A
D6065+	Implant supported porcelain/ceramic crown	Once per tooth every 7 years	50%	N/A
D6066+	Implant supported crown - porcelain fused to high noble alloys	Once per tooth every 7 years	50%	N/A
D6067+	Implant supported crown - high noble alloys	Once per tooth every 7 years	50%	N/A
D6082+	Implant supported crown - porcelain fused to predominantly base alloys	Once per tooth every 7 years	50%	N/A
D6083+	Implant supported crown - porcelain fused to noble alloys	Once per tooth every 7 years	50%	N/A

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Implant-related Services (continued)				
D6084+	Implant supported crown - porcelain fused to titanium and titanium alloys	Once per tooth every 7 years	50%	N/A
D6086+	Implant supported crown - predominantly base alloys	Once per tooth every 7 years	50%	N/A
D6087+	Implant supported crown - noble alloys	Once per tooth every 7 years	50%	N/A
D6088+	Implant supported crown - titanium and titanium alloys	Once per tooth every 7 years	50%	N/A
D6094+	Abutment supported crown - titanium and titanium alloys	Once per tooth every 7 years	50%	N/A
D6097+	Abutment supported crown - porcelain fused to titanium and titanium alloys	Once per tooth every 7 years	50%	N/A
Prosthodontic Services (Fixed)				
D6210+	Pontic - cast high noble metal Alternate benefit of D6211	Once per tooth every 7 years	50%	N/A
D6211+	Pontic - cast predominantly base metal	Once per tooth every 7 years	50%	N/A
D6212+	Pontic - cast noble metal Alternate benefit of D6211	Once per tooth every 7 years	50%	N/A
D6240+	Pontic - porcelain fused to high noble metal Alternate benefit of D6241	Once per tooth every 7 years	50%	N/A
D6241+	Pontic - porcelain fused to predominantly base metal	Once per tooth every 7 years	50%	N/A
D6242+	Pontic - porcelain fused to noble metal Alternate benefit of D6241	Once per tooth every 7 years	50%	N/A
D6245+	Pontic - porcelain/ceramic	Once per tooth every 7 years	50%	N/A
D6545+	Retainer - cast metal for resin bonded fixed prosthesis	Once per tooth every 7 years	50%	N/A
D6740+	Retainer crown - porcelain/ceramic Alternate benefit of D6751	Once per tooth every 7 years	50%	N/A
D6750+	Retainer crown - porcelain fused to high noble metal Alternate benefit of D6751	Once per tooth every 7 years	50%	N/A
D6751+	Retainer crown - porcelain fused to predominantly base metal	Once per tooth every 7 years	50%	N/A

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Prosthodontic Services (Fixed) (continued)				
D6752+	Retainer crown - porcelain fused to noble metal Alternate benefit of D6751	Once per tooth every 7 years	50%	N/A
D6790+	Retainer crown - full cast high noble metal Alternate benefit of D6791	Once per tooth every 7 years	50%	N/A
D6791+	Retainer crown - full cast predominantly base metal	Once per tooth every 7 years	50%	N/A
D6792+	Retainer crown - full cast noble metal Alternate benefit of D6791	Once per tooth every 7 years	50%	N/A
D6930	Re-cement or re-bond fixed partial denture	Once per tooth every 12 months	50%	N/A
Oral and Maxillofacial Surgery				
D7111	Extraction, coronal remnants - primary tooth	1 per tooth per lifetime	50%	N/A
D7140	Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	1 per tooth per lifetime	20%	N/A
D7210+	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1 per tooth per lifetime	20%	N/A
D7220+	Removal of impacted tooth - soft tissue	1 per tooth per lifetime	50%	N/A
D7230+	Removal of impacted tooth - partially bony	1 per tooth per lifetime	50%	N/A
D7240+	Removal of impacted tooth - completely bony	1 per tooth per lifetime	50%	N/A
D7241+	Removal of impacted tooth - completely bony, with unusual surgical complications	1 per tooth per lifetime	50%	N/A
D7250+	Removal of residual tooth roots (cutting procedure)	1 per tooth per lifetime	50%	N/A
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	Covered service	50%	N/A
D7261	Primary closure of a sinus perforation	Covered service	50%	N/A
D7286	Incisional biopsy of oral tissue-soft	Covered service	50%	N/A



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Oral and Maxillofacial Surgery <i>(continued)</i>				
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Covered service	50%	N/A
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	Covered service	50%	N/A
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Covered service	50%	N/A
D7410	Excision of benign lesion up to 1.25 cm	Covered service	50%	N/A
D7411	Excision of benign lesion greater than 1.25 cm	Covered service	50%	N/A
D7471	Removal of lateral exostosis (maxilla or mandible)	Covered service	50%	N/A
D7510	Incision and drainage of abscess - intraoral soft tissue	Covered service	50%	N/A
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	Covered service	50%	N/A
D7520	Incision and drainage of abscess - extraoral soft tissue	Covered service	50%	N/A
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	Covered service	50%	N/A
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	Covered service	50%	N/A
D7910	Suture of recent small wounds up to 5 cm	Covered service	50%	N/A
D7953	Bone replacement graft for ridge preservation - per site	Covered service	50%	N/A
D7961	Buccal / labial frenectomy (frenulectomy)	Covered service	50%	N/A
D7962	Lingual frenectomy (frenulectomy)	Covered service	50%	N/A
D7971	Excision of pericoronal gingiva	Covered service	50%	N/A

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Adjunctive General Services				
D9110	Palliative treatment of dental pain - per visit	Covered service	50%	N/A
D9210	Local anesthesia not in conjunction with operative or surgical procedures	Covered service	50%	N/A
D9215	Local anesthesia in conjunction with operative or surgical procedures	Covered service	50%	N/A
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	Covered service	50%	N/A
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Covered service	50%	N/A
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	Covered service	50%	N/A
D9440	Office visit - after regularly scheduled hours	Covered service	50%	N/A
D9610	Therapeutic parenteral drug, single administration	Covered service	50%	N/A
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	Covered service	50%	N/A
D9630	Drugs or medicaments dispensed in the office for home use	Covered service	50%	N/A
D9910	Application of desensitizing medicament	Covered service	50%	N/A
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	Covered service	50%	N/A
D9920	Behavior management, by report	Covered service	50%	N/A
D9950+	Occlusion analysis - mounted case	Covered service	50%	N/A
D9951+	Occlusal adjustment - limited	Covered service	50%	N/A



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