



2026

# Dental Quick Reference Guide

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





# Dental Quick Reference Guide

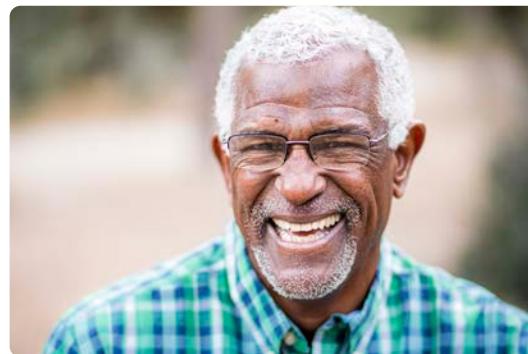
**Dental insurance can be confusing, and this guide is designed to help.**

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.

**888-965-1965 (TTY 711)**

**[conciergeHTA@htanc.com](mailto:conciergeHTA@htanc.com)**

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)
<b>Diagnostic and Preventive Dental Services (Routine)</b> - Prophylaxis (cleanings) - Radiographs/Diagnostic Imaging (X-rays) - Oral evaluations	No	0% coinsurance	<b>No Benefit</b>
<b>Comprehensive Dental Services</b> - Amalgam and composite fillings - Periodontal maintenance - Simple extractions	Yes	20% coinsurance after the annual deductible is met	<b>No Benefit</b>
<b>Comprehensive Dental Services</b> - 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	<b>No Benefit</b>

**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).***



**2026**

## Diabetes & Heart Care (HMO C-SNP)

### 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**

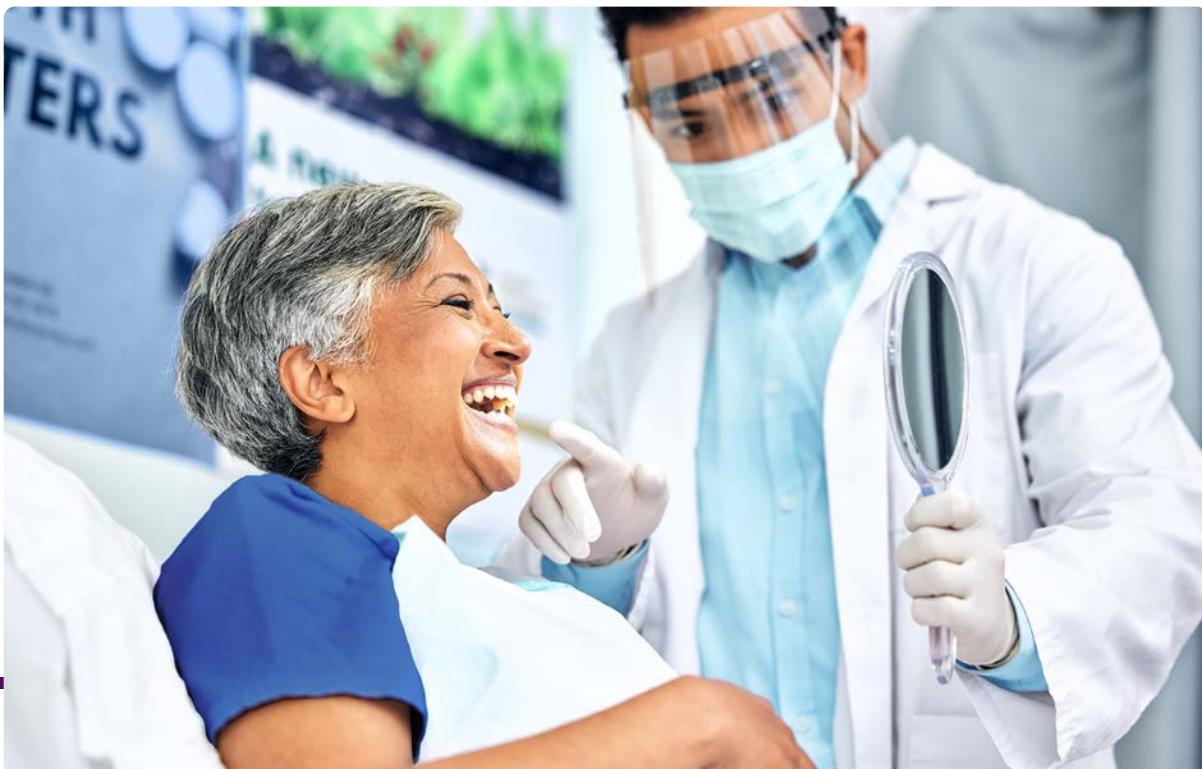
**Diabetes & Heart Care (HMO C- SNP)**



+ 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](http://www.htanc.com/members/member-resources).

<b>DIAGNOSTIC AND PREVENTIVE DENTAL SERVICES (ROUTINE)</b>				
<b>American Dental Association (ADA) Code</b>	<b>Dental Procedure Description</b> <i>(Easy to interpret description of the dental procedure code)</i>	<b>Frequency</b> <i>(How often your plan will pay for the procedure)</i>	<b>In-Network You Pay</b>	<b>Out-of-Network Not Covered</b>
<b>Preventive</b>				
<b>Dental Prophylaxis &amp; Office Visits</b>				
<b>D110</b>	Prophylaxis, adult	2 per calendar year	<b>0%</b>	N/A
<b>D9311</b>	Consultation with a medical health care professional	Covered service	<b>0%</b>	N/A
<b>D9995</b>	Teledentistry - synchronous; real-time encounter	Must be submitted with a covered procedure	<b>0%</b>	N/A
<b>D9996</b>	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	Must be submitted with a covered procedure	<b>0%</b>	N/A
<b>Diagnostic</b>				
<b>Clinical Oral Evaluations</b>				
<b>D0120</b>	Periodic Oral Evaluation - established patient	2 per calendar year	<b>0%</b>	N/A
<b>D0140</b>	Limited Oral Evaluation - problem focused	1 every 12 months	<b>0%</b>	N/A
<b>D0150</b>	Comprehensive Oral Evaluation - new or established patient	1 per 36 months	<b>0%</b>	N/A
<b>D0160</b>	Detailed and Extensive Oral Evaluation - problem focused, by report	1 every lifetime	<b>0%</b>	N/A
<b>D0170</b>	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	1 every lifetime	<b>0%</b>	N/A
<b>D0171</b>	Re-evaluation - post-operative office visit	Covered service	<b>0%</b>	N/A
<b>D0180</b>	Comprehensive periodontal evaluation - new or established patient	1 every 36 months	<b>0%</b>	N/A

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



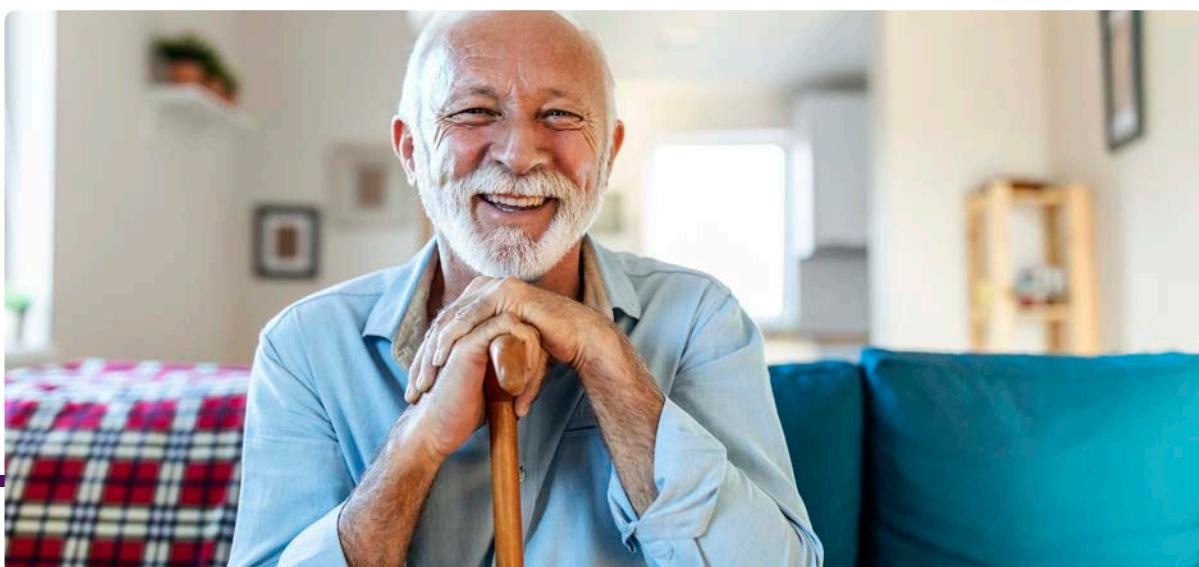
American Dental Association (ADA) Code	Dental Procedure Description <i>(Easy to interpret description of the dental procedure code)</i>	Frequency <i>(How often your plan will pay for the procedure)</i>	In-Network You Pay	Out-of-Network Not Covered
<b>COMPREHENSIVE DENTAL SERVICES</b>				
<b>Restorative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

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

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



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





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

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



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<b>Partial Dentures (continued)</b>				
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	1 set of full <b>OR</b> 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) <b>Alternate benefit of D5221</b>		50%	N/A
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) <b>Alternate benefit of D5222</b>		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

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<b>Adjustments/Repairs to Dentures</b>				
<b>D5410</b>	Adjust complete denture - maxillary	2 per calendar year	<b>50%</b>	N/A
<b>D5411</b>	Adjust complete denture - mandibular	2 per calendar year	<b>50%</b>	N/A
<b>D5421</b>	Adjust partial denture - maxillary	2 per calendar year	<b>50%</b>	N/A
<b>D5422</b>	Adjust partial denture - mandibular	2 per calendar year	<b>50%</b>	N/A
<b>D5511</b>	Repair broken complete denture base, mandibular	1 per 24 months	<b>50%</b>	N/A
<b>D5512</b>	Repair broken complete denture base, maxillary	1 per 24 months	<b>50%</b>	N/A
<b>D5520</b>	Replace missing or broken teeth - complete denture (each tooth)	1 per 24 months	<b>50%</b>	N/A
<b>D5611</b>	Repair resin partial denture base, mandibular	1 per 24 months	<b>50%</b>	N/A
<b>D5612</b>	Repair resin partial denture base, maxillary	1 per 24 months	<b>50%</b>	N/A
<b>D5621</b>	Repair cast partial framework, mandibular	1 per 24 months	<b>50%</b>	N/A
<b>D5622</b>	Repair cast partial framework, maxillary	1 per 24 months	<b>50%</b>	N/A
<b>D5630</b>	Repair or replace broken retentive clasping materials - per tooth	1 per 24 months	<b>50%</b>	N/A
<b>D5640</b>	Replace broken teeth - per tooth	1 per 24 months	<b>50%</b>	N/A
<b>D5650</b>	Add tooth to existing partial denture	1 per 24 months	<b>50%</b>	N/A
<b>D5660</b>	Add clasp to existing partial denture - per tooth	1 per 24 months	<b>50%</b>	N/A
<b>D5670</b>	Replace all teeth and acrylic on cast metal framework (maxillary)	1 per 24 months	<b>50%</b>	N/A
<b>D5671</b>	Replace all teeth and acrylic on cast metal framework (mandibular)	1 per 24 months	<b>50%</b>	N/A



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

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

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

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



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

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



**2026**

**Diabetes & Heart Care (HMO C-SNP)**

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