

Dental Quick Reference Guide

HealthTeam Advantage Plan I (PPO) H9808-004

HealthTeam Advantage Plan II (PPO) H9808-005

HealthTeam Advantage Eagle Plan (PPO) H9808-009



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 Plan I, Plan II, or the Eagle Plan, you can choose in-network dentists from Dominion Dental's North Carolina network, or you can select an out-of-network dental provider. Keep in mind that going out of network can result in higher out-of-pocket costs for you.



HealthTeam Advantage Plan I (PPO), Plan II (PPO), and Eagle Plan (PPO) include 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

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.

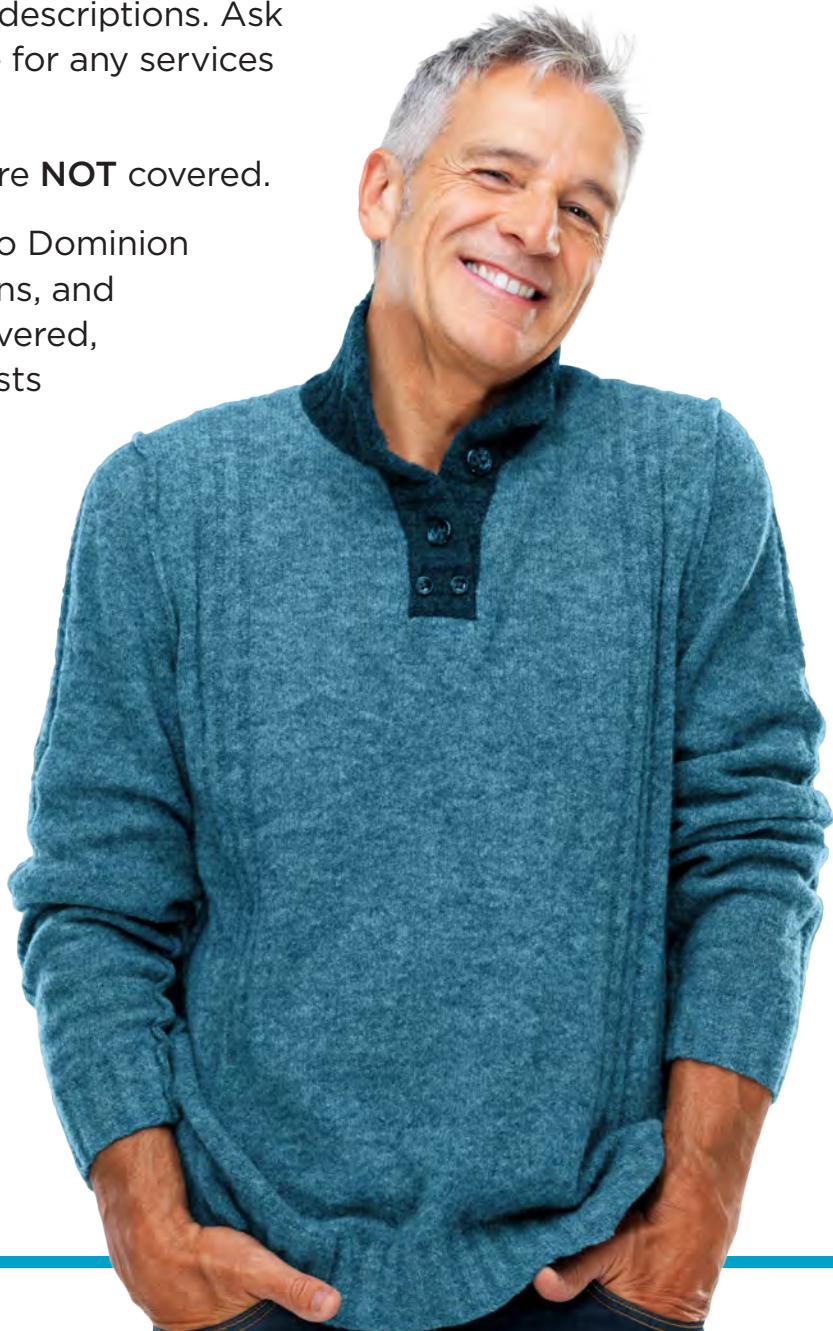
Every dental procedure has an American Dental Association (ADA) procedure code. All services in this guide are listed by ADA procedure code. It is generally a good idea to have the procedure code when you are looking up coverage, as the procedures have very specific descriptions. Ask your provider for 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 the difference between the Dominion Dental payment and the amount charged by the non-participating dentist, resulting in your out-of-pocket costs being higher.



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 plan covers both in-network and out-of-network dental care. **You must use a Dominion Dental participating dental provider for in-network coverage to apply.**

Benefit Year: January 1 through December 31, 2026

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

Annual Benefit Maximum (varies based on medical plan):

Plan I: \$1,500

Plan II: \$2,000

Eagle Plan: \$1,500

per person total per Benefit Year for Comprehensive dental services
(combined for in- and out-of-network covered dental services)

Office Visit Copay: \$0 copay per office visit

Important: If you see a dentist who is not part of the Dominion Dental Medicare Advantage Network, you will have to pay for a share of the service costs. You may also have to pay the difference between what your plan reimburses and what the dentist charges, which could result in higher out-of-pocket costs for you.

When you submit a claim for reimbursement, make sure to include the approved dental codes from your provider. You will be reimbursed up to the approved amount minus any member cost-sharing.

Note: *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) - Prophylaxis (cleanings) - Radiographs/Diagnostic Imaging (X-rays) - Oral evaluations | No | 0% coinsurance | 50% coinsurance plus any additional costs up to the dental provider's billed amount |
| Comprehensive Dental Services - Amalgam and composite fillings - Periodontal maintenance - Simple extractions | Yes | 20% coinsurance after the annual deductible is met | 50% coinsurance after the deductible is met plus any additional costs up to the dental provider's billed amount |
| Comprehensive Dental Services - 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 | 75% coinsurance after the deductible is met plus any additional costs up to the dental provider's billed amount |

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.
- ◆ Out-of-network dentists have not agreed to provide services at contracted fees. For services obtained out-of-network, the plan only pays up to a certain amount. If you choose to see an out-of-network dentist, you will be billed by that provider for any amount greater than what the plan pays.
- ◆ You may be billed by the out-of-network dental provider for any amount greater than the payment made by Dominion Dental Services, Inc., to the provider up to the provider's charge. Out-of-network/non-contracted dental providers are under no obligation to treat plan members, except in emergency situations. Benefits received out-of-network are subject to any benefit maximums, limitations, and/or exclusions.

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. This provision applies to both in-network and out-of-network services, subject to plan 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 PPO plans do 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 at an in-network dentist, the dentist will submit the claim on your behalf. When you see an out-of-network dentist, the dentist may submit a claim on your behalf. If a provider who is not in our network is not willing to bill us directly, you may have to pay up front and submit a request for reimbursement. If the out-of-network dentist does not submit the claim on your behalf, then you can submit it directly using the following instructions:

- ◆ Complete the American Dental Association (ADA) Claim Form located in the Member Resources section of the HealthTeam Advantage website, www.htanc.com/members/member-forms.
- ◆ The claim submission must contain the following information:
 - Full member name and member ID number
 - Full provider name and address
 - List of dental services rendered with the corresponding ADA code(s)
 - Proof of payment in the form of a receipt, check copy, Explanation of Benefits (EOB), or a ledger statement from the provider showing a positive payment against the services rendered
 - Additionally, any supporting documentation that may be necessary to support the dental services rendered, such as X-rays or clinical notes, etc., should accompany your claims submission.
- ◆ Mail all required claim information to:
Dominion Dental Services, Inc.
P.O. Box 211424, Eagan, MN 55121-0522
 - Once your claim request and any documentation have been reviewed and approved, payment will be sent to the mailing address listed on your account. To update your address or for assistance with submitting claims, contact your Healthcare Concierge at 888-965-1965 (TTY 711).
 - You have 365 days from date of service to submit a claim
 - Claims are paid within 30 days
- ◆ 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 HealthTeam Advantage Member ID card.
- ◆ Dental services are subject to our 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

Plan I (PPO) and Plan II (PPO), Eagle Plan (PPO)



+ 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 <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 You Pay |
|---|---|--|--------------------|------------------------|
| Preventive | | | | |
| Dental Prophylaxis & Office Visits | | | | |
| D1110 | Prophylaxis, adult | 2 per calendar year | 0% | 50% |
| D9311 | Consultation with a medical health care professional | Covered service | 0% | 50% |
| D9995 | Teledentistry - synchronous; real-time encounter | Must be submitted with a covered procedure | 0% | 50% |
| D9996 | Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review | Must be submitted with a covered procedure | 0% | 50% |
| Diagnostic | | | | |
| Clinical Oral Evaluations | | | | |
| D0120 | Periodic Oral Evaluation - established patient | 2 per calendar year | 0% | 50% |
| D0140 | Limited Oral Evaluation - problem focused | 1 every 12 months | 0% | 50% |
| D0150 | Comprehensive Oral Evaluation - new or established patient | 1 per 36 months | 0% | 50% |
| D0160 | Detailed and Extensive Oral Evaluation - problem focused, by report | 1 every lifetime | 0% | 50% |
| D0170 | Re-evaluation - limited, problem focused (established patient; not post-operative visit) | 1 every lifetime | 0% | 50% |
| D0171 | Re-evaluation - post-operative office visit | Covered service | 0% | 50% |
| D0180 | Comprehensive periodontal evaluation - new or established patient | 1 every 36 months | 0% | 50% |

| 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 You Pay |
|--|---|--|--------------------|------------------------|
| Radiographs/Diagnostic Imaging (X-rays) | | | | |
| D0210 | Intraoral - comprehensive series of radiographic images | 1 every 60 months | 0% | 50% |
| D0220 | Intraoral - periapical first radiographic image | Covered service | 0% | 50% |
| D0230 | Intraoral - periapical each additional radiographic image | Covered service | 0% | 50% |
| D0240 | Intraoral - occlusal radiographic image | Covered service | 0% | 50% |
| D0250 | Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector | Covered service | 0% | 50% |
| D0270 | Bitewing - single radiographic image | 2 per calendar year | 0% | 50% |
| D0272 | Bitewings - two radiographic images | 2 per calendar year | 0% | 50% |
| D0273 | Bitewings - three radiographic images | 2 per calendar year | 0% | 50% |
| D0274 | Bitewings - four radiographic images | 2 per calendar year | 0% | 50% |
| D0277 | Vertical bitewings - 7 to 8 radiographic images | 2 per calendar year | 0% | 50% |
| D0322 | Tomographic survey | Covered service | 0% | 50% |
| D0330 | Panoramic radiographic image | 1 every 60 months | 0% | 50% |
| D0470 | Diagnostic casts | 1 every 60 months | 0% | 50% |



COMPREHENSIVE DENTAL SERVICES

| 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 You Pay |
|---|---|--|--------------------|------------------------|
| Restorative Services | | | | |
| Amalgam and Composite Restorations | | | | |
| D2140 | Amalgam Filling - one surface, primary or permanent | 1 per 24 months | 20% | 50% |
| D2150 | Amalgam Filling - two surfaces, primary or permanent | 1 per 24 months | 20% | 50% |
| D2160 | Amalgam Filling - three surfaces, primary or permanent | 1 per 24 months | 20% | 50% |
| D2161 | Amalgam Filling - four surfaces, primary or permanent | 1 per 24 months | 20% | 50% |
| D2330 | Resin-Based Composite, one surface, anterior | 1 per 24 months | 20% | 50% |
| D2331 | Resin-Based Composite, two surfaces, anterior | 1 per 24 months | 20% | 50% |
| D2332 | Resin-Based Composite, three surfaces, anterior | 1 per 24 months | 20% | 50% |
| D2335 | Resin-Based Composite, four or more surfaces or involving incisal angle (anterior) | 1 per 24 months | 20% | 50% |
| D2391 | Resin-Based Composite, one surface, posterior | 1 per 24 months | 20% | 50% |
| D2392 | Resin-Based Composite, two surfaces, posterior | 1 per 24 months | 20% | 50% |
| D2393 | Resin-Based Composite, three surfaces, posterior | 1 per 24 months | 20% | 50% |
| D2394 | Resin-Based Composite, four surfaces, posterior | 1 per 24 months | 20% | 50% |

| 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 You Pay |
|---|---|--|--------------------|------------------------|
| Restorative Services (continued) | | | | |
| Inlays/Onlays | | | | |
| D2510+ | Inlay - metallic - one surface | Once every 7 years | 50% | 75% |
| D2520+ | Inlay - metallic - two surfaces | Once every 7 years | 50% | 75% |
| D2530+ | Inlay - metallic - three or more surfaces | Once every 7 years | 50% | 75% |
| D2542+ | Onlay - metallic - two surfaces | Once every 7 years | 50% | 75% |
| D2543+ | Onlay - metallic - three surfaces | Once every 7 years | 50% | 75% |
| D2544+ | Onlay - metallic - four or more surfaces | Once every 7 years | 50% | 75% |
| D2610+ | Inlay - porcelain/ceramic - one surface Alternate benefit of D2510 | Once every 7 years | 50% | 75% |
| D2620+ | Inlay - porcelain/ceramic - two surfaces Alternate benefit of D2520 | Once every 7 years | 50% | 75% |
| D2630+ | Inlay - porcelain/ceramic - three or more surfaces Alternate benefit of D2530 | Once every 7 years | 50% | 75% |
| D2642+ | Onlay - porcelain/ceramic - two surfaces | Once every 7 years | 50% | 75% |
| D2643+ | Onlay - porcelain/ceramic - three surfaces | Once every 7 years | 50% | 75% |
| D2644+ | Onlay - porcelain/ceramic - four or more surfaces Alternate benefit of D2544 | Once every 7 years | 50% | 75% |
| D2650+ | Inlay - resin-based composite - one surface Alternate benefit of D2510 | Once every 7 years | 50% | 75% |
| D2651+ | Inlay - resin-based composite - two surfaces Alternate benefit of D2520 | Once every 7 years | 50% | 75% |
| D2652+ | Inlay - resin-based composite - three or more surfaces Alternate benefit of D2530 | Once every 7 years | 50% | 75% |
| D2662+ | Onlay - resin-based composite - two surfaces | Once every 7 years | 50% | 75% |
| D2663+ | Onlay - resin-based composite - three surfaces | Once every 7 years | 50% | 75% |
| D2664+ | Onlay - resin-based composite - four or more surfaces Alternate benefit of D2544 | Once every 7 years | 50% | 75% |

| 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 You Pay |
|--|---|--|--------------------|------------------------|
| Crowns | | | | |
| D2710+ | Crown - resin-based composite (indirect) | Once every 7 years | 50% | 75% |
| D2740+ | Crown - porcelain/ceramic Alternate benefit of D2751 | Once every 7 years | 50% | 75% |
| D2750+ | Crown - porcelain fused to high noble metal Alternate benefit of D2751 | Once every 7 years | 50% | 75% |
| D2751+ | Crown - porcelain fused to predominantly base metal | Once every 7 years | 50% | 75% |
| D2752+ | Crown - porcelain fused to noble metal Alternate benefit of D2751 | Once every 7 years | 50% | 75% |
| D2780+ | Crown - 3/4 cast high noble metal Alternate benefit of D2781 | Once every 7 years | 50% | 75% |
| D2781+ | Crown - 3/4 cast predominantly base metal | Once every 7 years | 50% | 75% |
| D2782+ | Crown - 3/4 cast noble metal Alternate benefit of D2781 | Once every 7 years | 50% | 75% |
| D2783+ | Crown - 3/4 porcelain/ceramic Alternate benefit of D2781 | Once every 7 years | 50% | 75% |
| D2790+ | Crown - full cast high noble metal Alternate benefit of D2791 | Once every 7 years | 50% | 75% |
| D2791+ | Crown - full cast predominantly base metal | Once every 7 years | 50% | 75% |
| D2792+ | Crown - full cast noble metal Alternate benefit of D2791 | Once every 7 years | 50% | 75% |
| D2799 | Interim crown - further treatment or completion of diagnosis necessary prior to final impression | Once every 7 years | 50% | 75% |



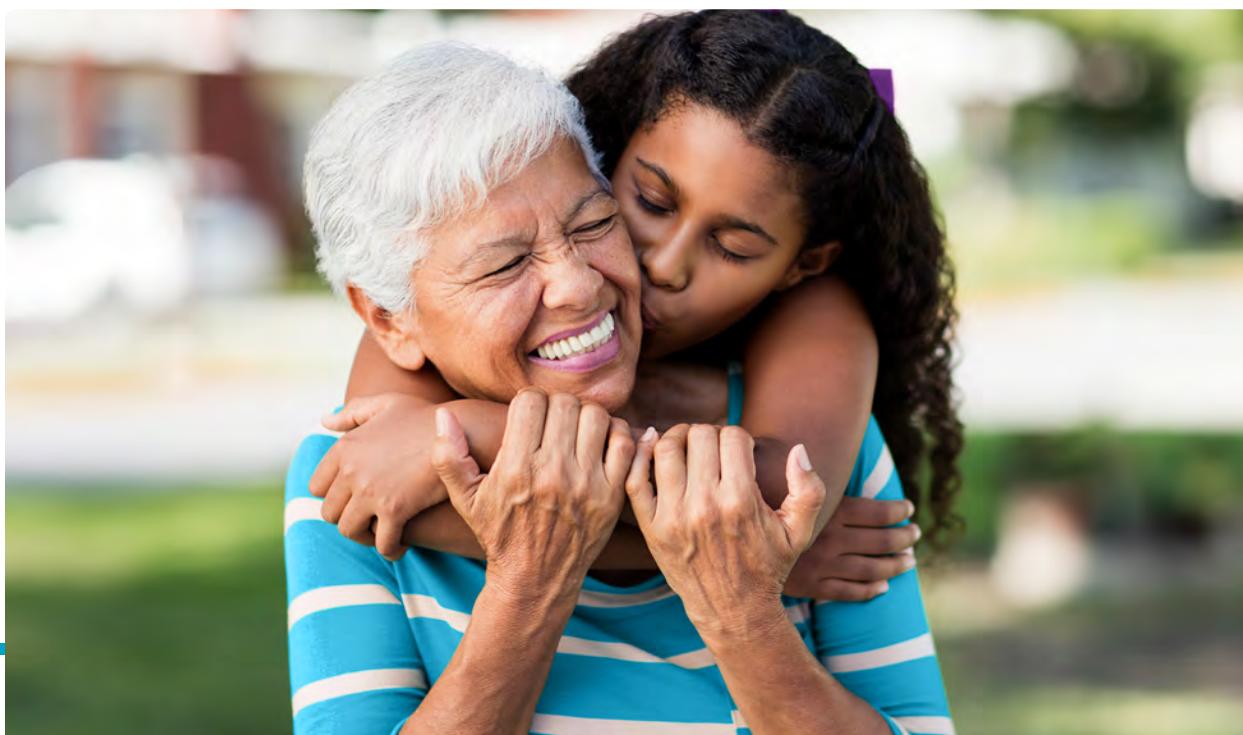
| American Dental Association (ADA) Code | Dental Procedure Description <i>(Easy to interpret description of the dental procedure code)</i> | Frequency <i>(How often your plan will pay for the procedure)</i> | In-Network You Pay | Out-of-Network You Pay |
|--|---|--|--------------------|------------------------|
| Other Restorative Services | | | | |
| D2910 | Re-cement or re-bond inlay, onlay or partial coverage restoration | Once every 12 months | 50% | 75% |
| D2915 | Re-cement or re-bond indirectly fabricated or prefabricated post and core | Once every 12 months | 50% | 75% |
| D2920 | Re-cement or re-bond crown | Once every 12 months | 50% | 75% |
| D2931 | Prefabricated stainless steel crown - permanent tooth | Once every 7 years | 50% | 75% |
| D2932 | Prefabricated resin crown | Once every 7 years | 50% | 75% |
| D2940 | Protective Restoration | Covered service | 50% | 75% |
| D2950+ | Core buildup, including any pins when required | Once every 7 years | 50% | 75% |
| D2951+ | Pin retention - per tooth, in addition to restoration | Covered service | 50% | 75% |
| D2952+ | Post and core in addition to crown, indirectly fabricated | Once every 7 years | 50% | 75% |
| D2953+ | Each additional indirectly fabricated post - same tooth | Covered service | 50% | 75% |
| D2954+ | Prefabricated post and core in addition to crown | Once every 7 years | 50% | 75% |
| D2955 | Post removal | Covered service | 50% | 75% |
| D2957+ | Each additional prefabricated post - same tooth | Covered service | 50% | 75% |
| D2971+ | Additional procedures to customize a crown to fit under an existing partial denture framework | Covered service | 50% | 75% |
| D2980 | Crown repair necessitated by restorative material failure | Covered service | 50% | 75% |



| 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 You Pay |
|--|---|--|--------------------|------------------------|
| Endodontic Services | | | | |
| D3110+ | Pulp cap - direct (excluding final restoration) | Covered service | 50% | 75% |
| D3120+ | Pulp cap - direct (excluding final restoration) | Covered service | 50% | 75% |
| D3220+ | Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | Covered service | 50% | 75% |
| D3221+ | Pulpal debridement, primary or permanent teeth | Covered service | 50% | 75% |
| D3310, D3320, D3330 | Endodontic therapy (excluding final restoration) | One per tooth per lifetime | 50% | 75% |
| D3331 | Treatment of root canal obstruction; non-surgical access | Covered service | 50% | 75% |
| D3332 | Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | Covered service | 50% | 75% |
| D3333 | Internal root repair of perforation defects | Covered service | 50% | 75% |
| D3346, D3347, D3348 | Retreatment of previous root canal therapy | One per tooth per lifetime | 50% | 75% |
| D3410, D3421, D3425, D3426 | Apicoectomy | Covered service | 50% | 75% |
| D3430+ | Retrograde filling - per root | One per tooth per lifetime | 50% | 75% |
| D3450 | Root amputation - per root | Covered service | 50% | 75% |
| D3950+ | Canal preparation and fitting of preformed dowel or post | Covered service | 50% | 75% |

| 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 You Pay |
|--|---|--|--------------------|------------------------|
| Periodontal Services | | | | |
| D4210+ | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | Covered service | 50% | 75% |
| D4211+ | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | Covered service | 50% | 75% |
| D4212+ | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | Covered service | 50% | 75% |
| D4240+ | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | Covered service | 50% | 75% |
| D4241+ | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | Covered service | 50% | 75% |
| D4249+ | Clinical crown lengthening - hard tissue | Covered service | 50% | 75% |
| 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% | 75% |
| 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% | 75% |
| D4263+ | Bone replacement graft - retained natural tooth - first site in quadrant | Covered service | 50% | 75% |
| D4264+ | Bone replacement graft - retained natural tooth - each additional site in quadrant | Covered service | 50% | 75% |
| D4266+ | Guided tissue regeneration, natural teeth - resorbable barrier, per site | Once per lifetime | 50% | 75% |
| D4267+ | Guided tissue regeneration, natural teeth - non-resorbable barrier, per site | Once per lifetime | 50% | 75% |
| D4270+ | Pedicle soft tissue graft procedure | Once per lifetime | 50% | 75% |
| 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% | 75% |

| 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 You Pay |
|---|--|--|--------------------|------------------------|
| 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% | 75% |
| D4341+ | Periodontal scaling and root planing - four or more teeth per quadrant | 1 per quadrant every 24 months | 50% | 75% |
| D4342+ | Periodontal scaling and root planing - one to three teeth per quadrant | 1 per quadrant every 24 months | 50% | 75% |
| 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% | 75% |
| D4355 | Full mouth debridement - to enable a comprehensive oral evaluation and diagnosis on a subsequent visit | 1 per lifetime | 50% | 75% |
| D4910 | Periodontal maintenance | 2 per calendar year | 20% | 50% |
| Prosthodontic Services (Removable) | | | | |
| Complete Dentures | | | | |
| D5110 | Complete denture - maxillary | 1 set of full OR partial dentures every 7 years | 50% | 75% |
| D5120 | Complete denture - mandibular | | 50% | 75% |
| D5130 | Immediate denture - maxillary | | 50% | 75% |
| D5140 | Immediate denture - mandibular | | 50% | 75% |



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|--|--|--|--------------------|------------------------|
| 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% | 75% |
| D5212 | Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) | | 50% | 75% |
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) | | 50% | 75% |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) | | 50% | 75% |
| D5221 | Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) | | 50% | 75% |
| D5222 | Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) | | 50% | 75% |
| D5223 | Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) Alternate benefit of D5221 | | 50% | 75% |
| D5224 | Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) Alternate benefit of D5222 | | 50% | 75% |
| D5225 | Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) | | 50% | 75% |
| D5226 | Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) | | 50% | 75% |
| D5282 | Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary | | 50% | 75% |
| D5283 | Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular | | 50% | 75% |

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|--|---|--|--------------------|------------------------|
| Adjustments/Repairs to Dentures | | | | |
| D5410 | Adjust complete denture - maxillary | 2 per calendar year | 50% | 75% |
| D5411 | Adjust complete denture - mandibular | 2 per calendar year | 50% | 75% |
| D5421 | Adjust partial denture - maxillary | 2 per calendar year | 50% | 75% |
| D5422 | Adjust partial denture - mandibular | 2 per calendar year | 50% | 75% |
| D5511 | Repair broken complete denture base, mandibular | 1 per 24 months | 50% | 75% |
| D5512 | Repair broken complete denture base, maxillary | 1 per 24 months | 50% | 75% |
| D5520 | Replace missing or broken teeth - complete denture (each tooth) | 1 per 24 months | 50% | 75% |
| D5611 | Repair resin partial denture base, mandibular | 1 per 24 months | 50% | 75% |
| D5612 | Repair resin partial denture base, maxillary | 1 per 24 months | 50% | 75% |
| D5621 | Repair cast partial framework, mandibular | 1 per 24 months | 50% | 75% |
| D5622 | Repair cast partial framework, maxillary | 1 per 24 months | 50% | 75% |
| D5630 | Repair or replace broken retentive clasping materials - per tooth | 1 per 24 months | 50% | 75% |
| D5640 | Replace broken teeth - per tooth | 1 per 24 months | 50% | 75% |
| D5650 | Add tooth to existing partial denture | 1 per 24 months | 50% | 75% |
| D5660 | Add clasp to existing partial denture - per tooth | 1 per 24 months | 50% | 75% |
| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | 1 per 24 months | 50% | 75% |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | 1 per 24 months | 50% | 75% |



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|--|---|--|--------------------|------------------------|
| Rebase/Reline Dentures | | | | |
| D5710 | Rebase complete maxillary denture | 1 per 24 months | 50% | 75% |
| D5711 | Rebase complete mandibular denture | 1 per 24 months | 50% | 75% |
| D5720 | Rebase maxillary partial denture | 1 per 24 months | 50% | 75% |
| D5721 | Rebase mandibular partial denture | 1 per 24 months | 50% | 75% |
| D5730 | Reline complete maxillary denture (direct) | 1 per 24 months | 50% | 75% |
| D5731 | Reline complete mandibular denture (direct) | 1 per 24 months | 50% | 75% |
| D5740 | Reline maxillary partial denture (direct) | 1 per 24 months | 50% | 75% |
| D5741 | Reline mandibular partial denture (direct) | 1 per 24 months | 50% | 75% |
| D5750 | Reline complete maxillary denture (indirect) | 1 per 24 months | 50% | 75% |
| D5751 | Reline complete mandibular denture (indirect) | 1 per 24 months | 50% | 75% |
| D5760 | Reline maxillary partial denture (indirect) | 1 per 24 months | 50% | 75% |
| D5761 | Reline mandibular partial denture (indirect) | 1 per 24 months | 50% | 75% |
| Additional Denture Procedures | | | | |
| D5810 | Interim complete denture (maxillary) | 1 set of full OR partial dentures every 7 years | 50% | 75% |
| D5811 | Interim complete denture (mandibular) | 1 set of full OR partial dentures every 7 years | 50% | 75% |
| D5820 | Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary | 1 set of full OR partial dentures every 7 years | 50% | 75% |
| D5821 | Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular | 1 set of full OR partial dentures every 7 years | 50% | 75% |
| D5850 | Tissue conditioning, maxillary | Once every 7 years | 50% | 75% |
| D5851 | Tissue conditioning, mandibular | Once every 7 years | 50% | 75% |
| D5863+ | Overdenture – complete maxillary Alternate benefit of D5110 | 1 set of full OR partial dentures every 7 years | 50% | 75% |
| D5864+ | Overdenture – partial maxillary Alternate benefit D5213 | 1 set of full OR partial dentures every 7 years | 50% | 75% |

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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% | 75% |
| D5866+ | Overdenture - partial mandibular Alternate benefit of D5214 | 1 set of full OR partial dentures every 7 years | 50% | 75% |
| D5867 | Replacement of replaceable part of semi-precision or precision attachment, per attachment | 1 per 24 months | 50% | 75% |
| D5875 | Modification of removable prosthesis following implant surgery | Covered service | 50% | 75% |
| Implant-related Services | | | | |
| D6058+ | Abutment supported porcelain/ceramic crown | Once per tooth every 7 years | 50% | 75% |
| D6059+ | Abutment supported porcelain fused to metal crown (high noble metal) | Once per tooth every 7 years | 50% | 75% |
| D6060+ | Abutment supported porcelain fused to metal crown (predominantly base metal) | Once per tooth every 7 years | 50% | 75% |
| D6061+ | Abutment supported porcelain fused to metal crown (noble metal) | Once per tooth every 7 years | 50% | 75% |
| D6062+ | Abutment supported cast metal crown (high noble metal) | Once per tooth every 7 years | 50% | 75% |
| D6063+ | Abutment supported cast metal crown (predominantly base metal) | Once per tooth every 7 years | 50% | 75% |
| D6064+ | Abutment supported cast metal crown (noble metal) | Once per tooth every 7 years | 50% | 75% |
| D6065+ | Implant supported porcelain/ceramic crown | Once per tooth every 7 years | 50% | 75% |
| D6066+ | Implant supported crown - porcelain fused to high noble alloys | Once per tooth every 7 years | 50% | 75% |
| D6067+ | Implant supported crown - high noble alloys | Once per tooth every 7 years | 50% | 75% |
| D6082+ | Implant supported crown - porcelain fused to predominantly base alloys | Once per tooth every 7 years | 50% | 75% |
| D6083+ | Implant supported crown - porcelain fused to noble alloys | Once per tooth every 7 years | 50% | 75% |

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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% | 75% |
| D6086+ | Implant supported crown - predominantly base alloys | Once per tooth every 7 years | 50% | 75% |
| D6087+ | Implant supported crown - noble alloys | Once per tooth every 7 years | 50% | 75% |
| D6088+ | Implant supported crown - titanium and titanium alloys | Once per tooth every 7 years | 50% | 75% |
| D6094+ | Abutment supported crown - titanium and titanium alloys | Once per tooth every 7 years | 50% | 75% |
| D6097+ | Abutment supported crown - porcelain fused to titanium and titanium alloys | Once per tooth every 7 years | 50% | 75% |
| Prosthodontic Services (Fixed) | | | | |
| D6210+ | Pontic - cast high noble metal Alternate benefit of D6211 | Once per tooth every 7 years | 50% | 75% |
| D6211+ | Pontic - cast predominantly base metal | Once per tooth every 7 years | 50% | 75% |
| D6212+ | Pontic - cast noble metal Alternate benefit of D6211 | Once per tooth every 7 years | 50% | 75% |
| D6240+ | Pontic - porcelain fused to high noble metal Alternate benefit of D6241 | Once per tooth every 7 years | 50% | 75% |
| D6241+ | Pontic - porcelain fused to predominantly base metal | Once per tooth every 7 years | 50% | 75% |
| D6242+ | Pontic - porcelain fused to noble metal Alternate benefit of D6241 | Once per tooth every 7 years | 50% | 75% |
| D6245+ | Pontic - porcelain/ceramic | Once per tooth every 7 years | 50% | 75% |
| D6545+ | Retainer - cast metal for resin bonded fixed prosthesis | Once per tooth every 7 years | 50% | 75% |
| D6740+ | Retainer crown - porcelain/ceramic Alternate benefit of D6751 | Once per tooth every 7 years | 50% | 75% |
| D6750+ | Retainer crown - porcelain fused to high noble metal Alternate benefit of D6751 | Once per tooth every 7 years | 50% | 75% |
| D6751+ | Retainer crown - porcelain fused to predominantly base metal | Once per tooth every 7 years | 50% | 75% |

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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% | 75% |
| D6790+ | Retainer crown - full cast high noble metal Alternate benefit of D6791 | Once per tooth every 7 years | 50% | 75% |
| D6791+ | Retainer crown - full cast predominantly base metal | Once per tooth every 7 years | 50% | 75% |
| D6792+ | Retainer crown - full cast noble metal Alternate benefit of D6791 | Once per tooth every 7 years | 50% | 75% |
| D6930 | Re-cement or re-bond fixed partial denture | Once per tooth every 12 months | 50% | 75% |
| Oral and Maxillofacial Surgery | | | | |
| D7111 | Extraction, coronal remnants - primary tooth | 1 per tooth per lifetime | 50% | 75% |
| D7140 | Extraction - erupted tooth or exposed root (elevation and/or forceps removal) | 1 per tooth per lifetime | 20% | 50% |
| 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% | 50% |
| D7220+ | Removal of impacted tooth - soft tissue | 1 per tooth per lifetime | 50% | 75% |
| D7230+ | Removal of impacted tooth - partially bony | 1 per tooth per lifetime | 50% | 75% |
| D7240+ | Removal of impacted tooth - completely bony | 1 per tooth per lifetime | 50% | 75% |
| D7241+ | Removal of impacted tooth - completely bony, with unusual surgical complications | 1 per tooth per lifetime | 50% | 75% |
| D7250+ | Removal of residual tooth roots (cutting procedure) | 1 per tooth per lifetime | 50% | 75% |
| D7251 | Coronectomy - intentional partial tooth removal, impacted teeth only | Covered service | 50% | 75% |
| D7261 | Primary closure of a sinus perforation | Covered service | 50% | 75% |
| D7286 | Incisional biopsy of oral tissue-soft | Covered service | 50% | 75% |

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|---|---|--|--------------------|------------------------|
| Oral and Maxillofacial Surgery (continued) | | | | |
| D7310 | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | Covered service | 50% | 75% |
| D7311 | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | Covered service | 50% | 75% |
| D7320 | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | Covered service | 50% | 75% |
| D7410 | Excision of benign lesion up to 1.25 cm | Covered service | 50% | 75% |
| D7411 | Excision of benign lesion greater than 1.25 cm | Covered service | 50% | 75% |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | Covered service | 50% | 75% |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | Covered service | 50% | 75% |
| D7511 | Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) | Covered service | 50% | 75% |
| D7520 | Incision and drainage of abscess - extraoral soft tissue | Covered service | 50% | 75% |
| D7521 | Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) | Covered service | 50% | 75% |
| D7550 | Partial osteotomy/sequestrectomy for removal of non-vital bone | Covered service | 50% | 75% |
| D7910 | Suture of recent small wounds up to 5 cm | Covered service | 50% | 75% |
| D7953 | Bone replacement graft for ridge preservation - per site | Covered service | 50% | 75% |
| D7961 | Buccal / labial frenectomy (frenulectomy) | Covered service | 50% | 75% |
| D7962 | Lingual frenectomy (frenulectomy) | Covered service | 50% | 75% |
| D7971 | Excision of pericoronal gingiva | Covered service | 50% | 75% |

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| Adjunctive General Services | | | | |
| D9110 | Palliative treatment of dental pain - per visit | Covered service | 50% | 75% |
| D9210 | Local anesthesia not in conjunction with operative or surgical procedures | Covered service | 50% | 75% |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures | Covered service | 50% | 75% |
| D9230 | Inhalation of nitrous oxide/analgesia, anxiolysis | Covered service | 50% | 75% |
| D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | Covered service | 50% | 75% |
| D9430 | Office visit for observation (during regularly scheduled hours) - no other services performed | Covered service | 50% | 75% |
| D9440 | Office visit - after regularly scheduled hours | Covered service | 50% | 75% |
| D9610 | Therapeutic parenteral drug, single administration | Covered service | 50% | 75% |
| D9612 | Therapeutic parenteral drugs, two or more administrations, different medications | Covered service | 50% | 75% |
| D9630 | Drugs or medicaments dispensed in the office for home use | Covered service | 50% | 75% |
| D9910 | Application of desensitizing medicament | Covered service | 50% | 75% |
| D9911 | Application of desensitizing resin for cervical and/or root surface, per tooth | Covered service | 50% | 75% |
| D9920 | Behavior management, by report | Covered service | 50% | 75% |
| D9950+ | Occlusion analysis - mounted case | Covered service | 50% | 75% |
| D9951+ | Occlusal adjustment - limited | Covered service | 50% | 75% |



2026

Plan I (PPO) and Plan II (PPO), Eagle Plan (PPO)

Have Dental Coverage Questions?

If you have any questions about your coverage, call or email your Healthcare Concierge for assistance.

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Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see the Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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