

## SECTION 11: MEDICARE ADVANTAGE (MA) PLANS

### A. 2026 HMSA Akamai Advantage Plans

As of JAN 1, 2023, select Akamai Advantage Medical plans include preventative and basic dental coverage.

If you are a participating dentist in HMSA's Medicare Advantage network, you are considered in-network for members of the HMSA Akamai Advantage plans. You will be reimbursed at your current HMSA contracted MA fee schedule. Please refer to the [Medicare Advantage Manual](#).

To check eligibility and benefits, Providers may go online to [mydentalcoverage.com](https://mydentalcoverage.com) or contact Dental Customer Service from Oahu at **808-948-6440** or from neighboring islands at **1-800-792-4672**.

**Dental Claims should be submitted electronically using Payor ID HMSA1** or mailed to the following address:

HMSA Dental Claims  
P.O. Box 69436  
Harrisburg, PA 17106-9436

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

## B. Covered Services Embedded in Member's HMSA Akamai Advantage Plans

PROC CODE	CLASS	PROCEDURE DESCRIPTION	FREQUENCY/LIMITATION	Standard (N07) Complete (N09) PAR / NONPAR	Standard Plus (N08) Complete Plus (N10) PAR / NONPAR	D-SNP (N11) PAR / NONPAR
0120	DIAG	Periodic oral evaluation – established patient	2 per calendar year (combined frequency with 0140 and 0150)	100%/60%	100%/60%	100%/70%
0140	DIAG	Limited oral evaluation – problem focused	1 per calendar year (combined frequency with 0120 and 0150)	100%/60%	100%/60%	100%/70%
0150	DIAG	Comprehensive oral evaluation – new or established patient	1 per lifetime (combined frequency with 0120 and 0140)	100%/60%	100%/60%	100%/70%
0270	DIAG	Bitewing – single radiographic image	1 set per calendar year (any of these codes 0270, 0272, 0273, 0274, 0277 constitute a set, except when done within 12 months of 0210 or 0330)  NOTE: Bitewings done within 12 months of an FMX or Pano will not be covered.	100%/60%	100%/60%	100%/70%
0272	DIAG	Bitewings – two radiographic images				
0273	DIAG	Bitewings – three radiographic images				
0274	DIAG	Bitewings – four radiographic images				
0277	DIAG	Vertical bitewings – 7-8 radiographic images				
0210	DIAG	Intraoral – complete series of radiographic images	1 set per five years (any of these codes 0210 or 0330 constitute a set)	100%/60%	100%/60%	100%/70%
0330	DIAG	Panoramic radiographic image				

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				PAR / NONPAR	PAR / NONPAR	PAR / NONPAR
1110	PREV	Prophylaxis - adult	2 per calendar year (Combined with D4346 - Max of 2 cleanings total)	100%/60%	100%/60%	100%/70%
1206	PREV	Topical application of fluoride varnish	2 per calendar year (No age limit)	100%/60%	100%/60%	100%/70%
1208	PREV	Topical application of fluoride – excluding varnish				
1354	PREV	Application of caries arresting medicament – per tooth	2 treatments of caries arresting medicament per tooth, per calendar year	100%/60%	100%/60%	100%/70%
2140	BASIC	Amalgam – 1 surface, primary or permanent	Two (2) restorations per calendar year (Combined with D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394)	100%/60%	100%/60%	100%/70%
2150	BASIC	Amalgam – 2 surfaces, primary or permanent				
2160	BASIC	Amalgam – 3 surfaces, primary or permanent				
2161	BASIC	Amalgam – 4 surfaces, primary or permanent				
2330	BASIC	Resin-based composite – 1 surface, anterior				
2331	BASIC	Resin-based composite – 2 surfaces, anterior				
2332	BASIC	Resin-based composite – 3 surfaces, anterior				

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2335	BASIC	Resin-based composite – 4 or more surfaces, or involving incisal angle (anterior)	Two (2) restorations per calendar year (Combined with D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394)	100%/60%	100%/60%	100%/70%
2391	BASIC	Resin based composite – 1 surface, posterior				
2392	BASIC	Resin based composite – 2 surfaces, posterior				
2393	BASIC	Resin based composite – 3 surfaces, posterior				
2394	BASIC	Resin based composite – 4 or more surfaces, posterior				
2740	MAJOR	Crown – porcelain/ceramic	One (1) crown per calendar year following root canal procedure on the same tooth  Combined with D2740, D2750, D2751, D2752, D2790, D2791, D2792.  Replacement crowns once every 5 yrs with history of root canal	<b>Not Covered</b>	100%/60%	100%/70%
2750	MAJOR	Crown – porcelain fused to high noble metal				
2751	MAJOR	Crown – porcelain fused to predominantly base metal				
2752	MAJOR	Crown – porcelain fused to noble metal				
2790	MAJOR	Crown – full cast high noble metal				
2791	MAJOR	Crown – full cast predominantly base metal				
2792	MAJOR	Crown – full cast noble metal				

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3310	BASIC	Endodontic Therapy, anterior tooth	One (1) root canal treatment per calendar year. Combined with D3310, D3320, D3330.	<b>Not Covered</b>	100%/60%	100%/70%
3320	BASIC	Endodontic Therapy, premolar tooth				
3330	BASIC	Endodontic Therapy – molar tooth				
4341	BASIC	Periodontal scaling and root planing – four or more teeth per quadrant	One (1) per quad every 24 months (either D4341 or D4342)	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
4342	BASIC	Periodontal scaling and root planing – one to three teeth per quadrant				
4346	PREV	Scaling in the presence of generalized moderate or severe gingival inflammation	2 per calendar year Combined with D1110 - Max of 2 cleanings total	100%/60%	100%/60%	100%/70%
5110	MAJOR	Complete denture, maxillary	1 per 5 calendar years	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5120	MAJOR	Complete denture, mandibular				
5130	MAJOR	Immediate denture - maxillary				
5140	MAJOR	Immediate denture - mandibular				
5211	MAJOR	Maxillary partial denture – resin base (including retentive/ clasp materials, rests, and teeth)	1 every 5 calendar years Combined with D5211, D5213, D5221, D5223, D5225, D5227, D5282, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%

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5212	MAJOR	Mandibular partial denture – resin base (including retentive/ clasping materials, rests, and teeth)	1 every 5 calendar years Combined with D5212, D5214, D5222, D5224, D5226, D5228, D5283, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5213	MAJOR	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	1 every 5 calendar years Combined with D5211, D5213, D5221, D5223, D5225, D5227, D5282, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5214	MAJOR	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	1 every 5 calendar years Combined with D5212, D5214, D5222, D5224, D5226, D5228, D5283, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5221	MAJOR	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	1 every 5 calendar years Combined with D5211, D5213, D5221, D5223, D5225, D5227, D5282, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%

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5222	MAJOR	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	1 every 5 calendar years Combined with D5212, D5214, D5222, D5224, D5226, D5228, D5283, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5223	MAJOR	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	1 every 5 calendar years Combined with D5211, D5213, D5221, D5223, D5225, D5227, D5282, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5224	MAJOR	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	1 every 5 calendar years Combined with D5212, D5214, D5222, D5224, D5226, D5228, D5283, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%

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5225	MAJOR	Maxillary partial denture – flexible base (including retentive/ clasp ing materials, rests, and teeth)	1 every 5 calendar years Combined with D5211, D5213, D5221, D5223, D5225, D5227, D5282, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5226	MAJOR	Mandibular partial denture – flexible base (including retentive/ clasp ing materials, rests, and teeth)	1 every 5 calendar years Combined with D5212, D5214, D5222, D5224, D5226, D5228, D5283, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5227	MAJOR	Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)	1 every 5 calendar years Combined with D5211, D5213, D5221, D5223, D5225, D5227, D5282, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5228	MAJOR	Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)	1 every 5 calendar years Combined with D5212, D5214, D5222, D5224, D5226, D5228, D5283, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5282	MAJOR	Removable unilateral partial denture – one piece cast metal (including retentive/clasp ing materials, rests, and teeth), maxillary	1 every 5 calendar years Combined with D5211, D5213, D5221, D5223, D5225, D5227, D5282, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%

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5283	MAJOR	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	1 every 5 calendar years Combined with D5212, D5214, D5222, D5224, D5226, D5228, D5283, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5284	MAJOR	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant	1 every 5 calendar years Combined with D5211, D5213, D5221, D5223, D5225, D5227, D5282, D5212, D5214, D5222, D5224, D5226, D5228, D5283, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5286	MAJOR	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant	1 every 5 calendar years Combined with D5211, D5213, D5221, D5223, D5225, D5227, D5282, D5212, D5214, D5222, D5224, D5226, D5228, D5283, D5284, D5286.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5410	MAJOR	Adjust complete denture – maxillary	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5411	MAJOR	Adjust complete denture – mandibular	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%

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5421	MAJOR	Adjust partial denture – maxillary	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5422	MAJOR	Adjust partial denture – mandibular	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5511	MAJOR	Repair broken complete denture base, mandibular	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5512	MAJOR	Repair broken complete denture base, maxillary	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5520	MAJOR	Replace missing or broken teeth – complete denture - per tooth	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5410, D5421, D5512, D5612, D5622, D5411, D5422, D5511, D5611, D5621, D5520, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%

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5611	MAJOR	Repair resin partial denture base, mandibular	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5612	MAJOR	Repair resin partial denture base, maxillary	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5622	MAJOR	Repair cast partial framework, maxillary	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5630	MAJOR	Repair or replace broken retentive/clasping materials – per tooth	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5410, D5421, D5512, D5612, D5622, D5411, D5422, D5511, D5611, D5621, D5520, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5640	MAJOR	Replace missing or broken teeth – partial denture - per tooth	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5410, D5421, D5512, D5612, D5622, D5411, D5422, D5511, D5611, D5621, D5520, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%

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5650	MAJOR	Add tooth to existing partial denture - per tooth	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5410, D5421, D5512, D5612, D5622, D5411, D5422, D5511, D5611, D5621, D5520, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5660	MAJOR	Add clasp to existing partial denture – per tooth	2 per calendar year with a max of 5 services per 5 calendar years Combined with D5410, D5421, D5512, D5612, D5622, D5411, D5422, D5511, D5611, D5621, D5520, D5630, D5640, D5650, D5660.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5710	MAJOR	Rebase complete maxillary denture	1 per calendar year Combined with D5710, D5720, D5730, D5740, D5750, D5760, D5765.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5711	MAJOR	Rebase complete mandibular denture	1 per calendar year Combined with D5711, D5721, D5731, D5741, D5751, D5761, D5765.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5720	MAJOR	Rebase maxillary partial denture	1 per calendar year Combined with D5710, D5720, D5730, D5740, D5750, D5760, D5765.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5721	MAJOR	Rebase mandibular partial denture	1 per calendar year Combined with D5711, D5721, D5731, D5741, D5751, D5761, D5765.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5730	MAJOR	Reline complete maxillary denture (direct)	1 per calendar year Combined with D5710, D5720, D5730, D5740, D5750, D5760, D5765.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5731	MAJOR	Reline complete mandibular denture (direct)	1 per calendar year Combined with D5711, D5721, D5731, D5741, D5751, D5761, D5765.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5740	MAJOR	Reline maxillary partial denture (direct)	1 per calendar year Combined with D5710, D5720, D5730, D5740, D5750, D5760, D5765.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%

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5741	MAJOR	Reline mandibular partial denture (direct)	1 per calendar year Combined with D5711, D5721, D5731, D5741, D5751, D5761, D5765.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5750	MAJOR	Reline complete maxillary denture (indirect)	1 per calendar year Combined with D5710, D5720, D5730, D5740, D5750, D5760, D5765.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5751	MAJOR	Reline complete mandibular denture (indirect)	1 per calendar year Combined with D5711, D5721, D5731, D5741, D5751, D5761, D5765.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5761	MAJOR	Reline mandibular partial denture (indirect)	1 per calendar year Combined with D5711, D5721, D5731, D5741, D5751, D5761, D5765.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
5765	MAJOR	Soft liner for complete or partial removable denture – indirect	1 per calendar year Combined with D5711, D5721, D5731, D5741, D5751, D5761, D5710, D5720, D5730, D5740, D5750, D5760, D5765.	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
7140	BASIC	Extraction, erupted tooth or exposed root	Four (4) extractions per calendar year  1 per tooth per lifetime	100%/60%	100%/60%	100%/70%
7210	BASIC	Extraction, (surgical removal of) erupted tooth requiring removal of bone and/or sectioning of tooth				
7220	BASIC	Removal of impacted tooth – soft tissue	Four (4) extractions per calendar year	<b>Not Covered</b>	<b>Not Covered</b>	100%/70%
7250	BASIC	Removal of residual tooth roots (cutting procedure)	1 per tooth per lifetime			
7251	BASIC	Coronectomy – intentional partial tooth removal, impacted teeth only				

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**\*PROCEDURE CODES NOT LISTED ABOVE ARE NOT COVERED FOR THIS PLAN\***

**C. Key Highlights**

All services for plans N07, N08, N09, and N10 are payable at 100% for PAR providers and 60% for NON-Par providers. All services for plan N11 are payable at 100% for PAR providers and 70% for NON-Par providers. This maximum applies to in-and out-of-network preventive and additional comprehensive dental services.

HMSA Akamai Advantage Dental Plans offer Oral Health for Total Health enhanced dental benefits as of JAN 1, 2023.

**D. Key Sample – HMSA Akamai Advantage Card**

		<b>Standard (PPO)</b>	
Subscriber Name <b>KIMO M ALOHA</b>		Group <b>M12440 MedicareRx</b> <small>Prescription Drug Coverage</small> H3832 007	
Subscriber ID <b>XLLA000012345678</b>		Primary Care Provider DR. NOKI HANA	
PLAN 1808401 RXBIN <b>004336</b> RXPCN <b>MEDDADV</b> RXGRP <b>RX3982</b> RXID <b>A000012345678</b>	MEDICAL <b>708</b> PART D <b>725</b>	DENTAL <b>N07</b> VISION <b>OMA</b> DMP CARE <b>S01</b>	
<small>Revised 02/14/2022</small> <b>HMSA</b> Akamai Advantage®			

  

	<b>hmsa.com/advantage</b> Customer Service: <b>(808) 948-6000</b> or <b>1 (800) 660-4672</b> TTY <b>711</b> For care when traveling out of state call: Blue Card <b>1 (800) 810-BLUE</b> Pharmacy/Help Desk: <b>1 (866) 693-4620</b> Dental Help Desk: <b>1 (800) 792-4672</b>
Do NOT bill Medicare. Claims for covered services must be filed with HMSA. Payment will be based on the member's eligibility at the time services are received. Medicare limiting charges may apply. Submit claims to: <b>HMSA - CLAIMS</b> P.O. Box 860 Honolulu, HI 96808-0860 Services rendered out-of-state, mail claims to: The local Blue Cross/Blue Shield of the service area. For Prescription Drug Benefit claims, mail to: <b>Medicare Part D Claims</b> P.O. Box 52066 Phoenix, AZ 85072-2066	<b>Blue Cross Blue Shield of Hawaii</b> 818 Keeaumoku St. Honolulu, HI 96814-2985 An Independent Licensee of the Blue Cross and Blue Shield Association <b>Business hours:</b> 7 days a week 8 a.m. to 8 p.m.

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.